GEORGE MASON UNIVERSITY | Student Health Services

Immunization Record Form

http://shs.gmu.edu/immunizations

FORM INSTRUCTIONS

- **FORM SUBMISSION DEADLINES: October 1 - Incoming summer/fall students March 1 - Incoming spring students**
- ALL students must complete and sign/initial Parts 1, 2, 3 & 4. If student is under 18 years of age, Part 2a must be completed.
- ALL students born after 12/31/1956 must provide proof of immunizations listed in Part 6. Part 6 must be completed and signed by a healthcare provider.
- This form, along with any applicable outside records, must be submitted by the deadline. Records that are late or incomplete will be assessed a late fee and a hold will be placed on the student's Patriot Web account, this will prevent class registration for the following semester. Please write G# on all pages that are being submitted.
- Submit forms via mail, email, fax, or in person to the Fairfax office. During September - April, records may be submitted to the Arlington or Science and Technology clinics (these clinics are not open during the summer).
- If a student is unable to provide appropriate documentation, immunizations and/or titers are available at Student Health for a fee.
- All records must be in English.

PART 1. PERSONAL INFORMATION -- TO BE COMPLETED BY ALL STUDENTS, PRINT LEGIBLY

Last Name	First Name	Student G#
U.S. Address		
City	State	Zip Code
Date of Birth	Home Phone	Cell Phone

PART 2. EMERGENCY CONTACT INFORMATION -- TO BE COMPLETED BY ALL STUDENTS

In the event of an emergency, I give Student Health Services permission to contact: Student initials for permission to contact _____

Name _____ Home Phone _____ Cell Phone _____

PART 2a. MINOR CONSENT -- ONLY IF STUDENT IS UNDER 18 YEARS AT TIME OF ENROLLMENT

Parental permission or the consent of a legal guardian must be obtained to provide medical or surgical care to minors. To avoid delays in treatment in the event of illness or accident, please obtain the signature of a parent/legal guardian if you are under 18 years of age at the time of enrollment.

I hereby authorize the staff of George Mason University Student Health Services to assess, test, administer vaccines, and if necessary, treat my minor or dependent as deemed advisable.

Parent/Guardian Signature _____ Date _____

Printed Name of Parent/Guardian _____ Relationship _____

PART 3. DISCLAIMER -- TO BE COMPLETED BY ALL STUDENTS

Student Health Services reserves the right to request supporting documentation of your immunization records and request titers and/or vaccinations at your expense.

Student Signature (physical) _____ Date _____

Submission of immunization form & any outside records

QUESTIONS? immunize@gmu.edu
703-993-2135

Fairfax Clinic
SUB 1, Rm 2349
4400 University Drive, 2D3
Fairfax, VA 22030
Fax: 703-993-4053

Arlington Clinic
Founders Hall, Rm B102
3351 Fairfax Drive
Arlington, VA 22201
Fax: 703-993-9425

Science & Technology Clinic
Colgan Hall, Rm 229
10900 University Blvd
Manassas, VA 20110
Fax: 703-993-1948

Student Name _____ G # _____

PART 4. TUBERCULOSIS SCREENING -- TO BE COMPLETED BY ALL STUDENTS AND/OR HEALTHCARE PROVIDER

The following tuberculosis (TB) screening questions are required for <u>all</u> students. Refer to below list of countries for Questions 1 and 2.

Select Yes or No

1. Were you born in a country where tuberculosis is endemic **<u>AND</u>** will arrive or have arrived in the U.S. within the last five (5) years? ☐ Yes ☐ No

Date Arrived or Intended Date to Arrive in U.S. _____ Country of birth _____

2. **Within the last five (5) years** have you travelled for **three (3) consecutive months** or more to countries where tuberculosis is endemic? ☐ Yes ☐ No

Date(s) of Travel last 5 years _____ Length of Stay _____

Country(ies) list _____

3. Have you had close contact with anyone who is or was sick with tuberculosis? ☐ Yes ☐ No

4. Have you ever tested positive for tuberculosis? ☐ Yes ☐ No

If yes, please provide documentation of history with chest x-ray report.

5. Do you have any medical conditions such as chronic renal failure, leukemia, or lymphoma, HIV infection or any other immunosuppressive disorder? ☐ Yes ☐ No

6. Do you have any symptoms of active tuberculosis, such as: cough >3 weeks, night sweats, fever, unexplained weight loss and/or fatigue? ☐ Yes ☐ No

7. Have you resided in, volunteered or worked in a high-risk congregate setting such as prisons, nursing homes, hospitals or homeless shelters? ☐ Yes ☐ No

Initials of student or healthcare provider _____

If answers to <u>ALL</u> the above questions are **NO**, <u>no</u> TB testing or chest x-ray is required; go to Part 6.

If the answer is <u>YES</u> to <u>ANY</u> of the above questions, George Mason University requires your healthcare provider to **complete Part 5** on the next page (tuberculosis test).

List of Countries for Questions 1 and 2 (WHO reference 2016-2020)

Angola	Indonesia	Peru
Azerbaijan	Kazakhstan	Philippines
Bangladesh	Kenya	Russian Federation
Belarus	Korea, Democratic People's	Sierra Leone
Botswana	Republic	Somalia
Brazil	Kyrgyzstan	South Africa
Cambodia	Lesotho	Swaziland
Cameroon	Liberia	Tajikistan
Central African Republic	Malawi	Thailand
Chad	Moldova (Rep)	Uganda
China	Mozambique	Ukraine
Congo, Democratic Republic of	Myanmar	UR Tanzania
Ethiopia	Namibia	Uzbekistan
Ghana	Nigeria	Vietnam
Guinea-Bissau	Pakistan	Zambia
India	Papua New Guinea	Zimbabwe

Student Name _____ G # _____

PART 5. TUBERCULOSIS TEST -- IF REQUIRED BY PART 4, MUST BE COMPLETED BY HEALTHCARE PROVIDER

If a test is required, it must be performed within 6 months from the first day of classes at Mason.

Has patient ever had a positive tuberculin skin test or blood test? ☐ Yes ☐ No

If No: complete Section A **If yes**: Date:_____ Result: _____ complete Section B & C

Has patient ever had BCG*? ☐ Yes ☐ No

***Students who have had BCG are still required to have a TB test**

Section A: Tuberculin Test - (Skin test OR blood test)

Skin Test: Date Placed: ___/___/___ Date Read: ___/___/___ Result: _____mm

Please record actual mm of induration, transverse diameter; if no induration, write "0".

OR

Blood Test: B Immunoassay blood test Date: ___/___/___ Result: ☐ Negative ☐ Positive

Section B: Chest X-Ray is required if TB test is positive or if history of positive TB test and no chest x-ray report.

A copy of the chest x-ray report and/or documentation of treatment must accompany this form

A new chest x-ray is not required if patient is currently undergoing or has completed LTBI treatment.

Date of Chest X-Ray: ___/___/___ Result: ☐ Normal ☐ Abnormal

Section C: Treatment for TB or LTBI

Documentation of treatment must accompany this form

Date treatment started: ___/___/___ Date treatment completed: ___/___/___

Name of medication:_____

Healthcare Provider Initials: _____

PART 6. REQUIRED IMMUNIZATIONS -- to be completed by a healthcare provider WHO must also complete and sign PART 8

TETANUS-DIPHTHERIA Booster must have been given within the past 10 years

_____/_____/_____ (Tdap) **OR** _____/_____/_____ (Td)

MEASLES, MUMPS, RUBELLA (MMR) **1)** ____/____/____ **(2)** ____/____/____

2 doses required at least 1 month apart. First dose must be given on or after one year of age; and after 1971 for combined MMR vaccine or after 1967 for individual doses

OR **ALL 3 OF THESE CRITERIA ARE MET:**

Measles (Rubeola)	**1)** ____/____/____	**(2)** ____/____/____
Mumps	**1)** ____/____/____	**(2)** ____/____/____
Rubella (German Measles)	**1)** ____/____/____	**(2)** ____/____/____

☐ **OR** Copy of titer lab work indicating **positive** immunity must accompany this form

HEPATITIS B (HBV) Must receive all three doses at appropriately spaced intervals to be considered fully immunized

	(1) ___/___/___	(2) ___/___/___	(3) ___/___/___
Check One	☐ Hepatitis B ☐ Twinrix	☐ Hepatitis B ☐ Twinrix	☐ Hepatitis B ☐ Twinrix

OR ☐ Copy of titer lab work indicating **positive** immunity must accompany this form

OR ☐ signed waiver on page 4 of this form

MENINGOCCOCAL (Meningitis ACYW) ___/___/___ Administered between the ages of 16 and 21

OR ☐ signed waiver on page 4 of this form **OR** ☐ over 22 years of age

Student Name _____ G # _____

PART 7. RECOMMENDED IMMUNIZATIONS -- to be completed by a healthcare provider who must also complete and sign PART 8

VARICELLA (chicken pox) **(1)___/___/___ (2) ___/___/___**

HUMAN PAPILLOMAVIRUS (HPV) **(1)___/___/___ (2) ___/___/___ (3) ___/___/___**

HEPATITIS A (If Twinrix, see Part 6, Hepatitis B) **(1)___/___/___ (2) ___/___/___**

OTHER **(1)___/___/___ (2) ___/___/___ (3) ___/___/___**

PART 8. HEALTHCARE PROVIDER INFORMATION AND SIGNATURE, ALL INFORMATION REQUIRED

☐ Transcribed Records ☐ Administered Vaccine(s)

Printed Name and Title			
Name of Practice or Clinic			
Address			
Phone Number			
Health Care Provider Signature		Date	

WAIVER OF IMMUNIZATION AGAINST HEPATITIS B DISEASE

Hepatitis B is a serious liver disease caused by the hepatitis B virus (HBV). HBV infection can affect people of all ages and lead to liver disease. The virus is found in the blood and body fluids of infected people it is most often spread among adults through sexual contact or by sharing needles and other drug paraphernalia with an infected person. HBV can also be spread in households of HBV-infected persons or by passage of the virus from an HBV-infected mother to her infant during birth. Hepatitis B can be a silent disease, often infecting many people without making them feel sick. Unfortunately, 30 percent of those infected with HBV are not aware that they are carriers and can infect others. Hepatitis B symptoms might include loss of appetite, fatigue, stomachache, nausea and vomiting, yellowing of the whites of the eyes (jaundice), and/or joint pain. Vaccination can help prevent people from contracting hepatitis B. The HBV vaccine is 96 percent effective following a series of three shots over a six-month period. The most common side effect of the vaccine is soreness at the injection site. Vaccine recipients cannot get the disease from the vaccine.

*I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at anytime. I have received and reviewed the information regarding hepatitis B and the availability and effectiveness of the hepatitis B vaccine. I have chosen **not** to be vaccinated (or I am unable to provide current vaccination records) against hepatitis B.*

Student Signature _____ Date _____ Parent/Guardian Signature, if student is a minor _____ Date _____

WAIVER OF IMMUNIZATION AGAINST MENINGOCOCCAL DISEASE

Meningitis is an inflammation of the linings of the brain and spinal cord. It is caused by bacteria called *Neisseria meningitidis.* The bacteria are transmitted through air-borne droplets of respiratory secretions and by direct contact with infected persons. Although bacterial meningitis occurs rarely and sporadically throughout the year, increased outbreaks occur among college students, especially those who live in residence halls. Early symptoms of meningococcal disease include fever, severe headache, stiff neck, rashes, and exhaustion. If not treated early, meningitis can lead to severe and permanent disabilities or even death. A vaccine is available that protects against four strains of the bacteria that cause meningitis in the United States: types A, C, Y, and W-135. These types account for nearly two-thirds of meningitis cases among college students. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. The vaccine is 85 to 100 percent effective.

*I have received and reviewed the information regarding meningococcal disease and the availability and effectiveness of the meningococcal vaccine. If in the future I want to be vaccinated with meningococcal vaccine, I can receive the vaccination at anytime. I have chosen **not** to be vaccinated against meningococcal disease.*

Student Signature _____ Date _____ Parent/Guardian Signature, if student is a minor _____ Date _____

EXEMPTIONS PERMISSABLE: DO NOT APPLY TO TUBERCULOSIS SCREENING/TESTING

Medical: Letter from healthcare provider must accompany this form.

Religious Exemption: Original, notarized Commonwealth of Virginia form CRE-1 required.