GEORGE MASON UNIVERSITY | Student Health Services

Immunization Record Form

shs.gmu.edu/immunizations

INSTRUCTIONS

Visit the website for office hours and more information.

- **Completed immunization forms are due by the FIRST DAY OF CLASSES FOR THE SEMESTER.**
- **All records must be in English. Student and Healthcare Provider must fill out the Immunization Form in ink ("see attached" is not acceptable documentation).**
- Student name and G# must be on each page of submitted form and records.
- ALL students must complete Parts 1 and 3. Part 2 must be completed by parent/guardian if student is under 18 years of age.
- ALL students born after 12/31/1956 must provide proof of immunizations listed in Part 5.
- Part 4 (if required), Part 5, Part 6 and Part 7 of this form must be completed and signed by a healthcare provider. Part 4 refers to whether a TB test is required based on answers from Part 3.
- Records that are late or incomplete after appropriate deadlines will be assessed a late fee and a hold will be placed on the student's Patriot Web account. The hold will prevent class registration for the following semester.
- Transcription service is available for a fee at Student Health Services. If a student is unable to provide appropriate documentation, immunizations and/or titers are also available for a fee.
- Student Health Services reserves the right to request supporting documentation of your immunization records and request titers and/or vaccinations at your expense.
- Students will receive communication from the Immunization Office regarding compliance/non-compliance through a secure message to their Mason email. The notification will state that they have a secure message and should log into the patient portal to read it. These messages may go to a spam/junk email; check or edit mail options.

SUBMIT FORM AND RECORDS (DO NOT FAX OR EMAIL)

Upload to Patient Portal (preferred method): https://gmu.medicatconnect.com. Students can check record status in the portal.

Print services (on campus) offers free scanning service for students.

Mail to or **drop off** in-person to a SHS clinic:

FAIRFAX CLINIC
SUB 1, Rm 2349
4400 University Dr., 2D3
Fairfax, VA 22030

ARLINGTON CLINIC
Van Metre Hall, Rm B102
3351 Fairfax Dr., 1H7
Arlington, VA 22201

SCIENCE & TECHNOLOGY CLINIC
Colgan Hall, Rm 229
10900 University Blvd., 6D1
Manassas, VA 20110

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

Last Name _____ First Name _____ Student G# _____

U.S. Address _____

City _____ State Select state Zip Code _____

Date of Birth _____ Home Phone _____ Cell Phone _____

PART 2. 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: _____

ALLOWABLE EXEMPTIONS: DO NOT APPLY TO TUBERCULOSIS SCREENING/TESTING

Medical: Mason Medical Exemption Form completed and signed by healthcare provider. Upload to the patient portal.

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

Student Name: _____ G # _____

PART 3. TUBERCULOSIS SCREENING - TO BE COMPLETED BY ALL STUDENTS

Tuberculosis (TB) screening is required for all students. Please answer the following questions.

Select Yes or No

1. Refer to list below: Were you born in a country where tuberculosis is endemic OR traveled to any country where tuberculosis is endemic for more than 4 weeks? *(Write country or circle from list)* ☐ Yes ☐ No

Country(ies) List _____

2. Have you had close contact with anyone who is or was sick with tuberculosis (TB)? ☐ Yes ☐ No

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

If yes, provide documentation of history of positive test AND chest x-ray report dated within the past 3 months.

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

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

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

If answers to ALL the above questions are NO, no TB testing or chest x-ray is required. If the answer is YES to ANY of the above questions, you are required to submit a tuberculosis test dated within the last 3 months (see Part 4).

List of Countries for Question 1 (ref. 2018 VDH.gov)

Afghanistan
Albania
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Cote d'Ivoire
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini (formerly Swaziland)
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana-Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Madagascar
Liberia
Libya
Lithuania
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar (Burma)
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Marina Island
North Korea (Democratic People's Republic)
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Korea (Republic of Korea)
South Sudan
Sri Lanka
Sudan
Suriname
Tanzania (United Republic)
Tajikistan
Thailand
Timor-Leste
Tokelau
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Vietnam
Yemen
Zambia
Zimbabwe

Student Name: _____ G # _____

PART 4. TUBERCULOSIS TEST - IF REQUIRED BY PART 3, TO BE COMPLETED AND INITIALED BY A HEALTHCARE PROVIDER. All lab reports and chest x-rays must be submitted with this form.

Students MUST undergo Tuberculin skin test (TST) OR have one Interferon Gamma Release Assay Test (IGRA) if THEY answered yes to 1 or more risk questions. All testing and x-rays must be dated less than 3 months from the first day of classes.

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

If No: complete Section A

If yes: Date:_____ Result: _____mm complete Section B & C

Students who have had BCG are required to have a TB test. It is recommended they do a TB Immunoassay Blood Test (IGRA)

Section A: TB Test - (Skin test OR Blood test) Copy of test/report must accompany the form

Skin Test: Date Placed:_____ Results: _____mm Date Read: _____
Must be 48-72 hours from placement

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

OR

Blood Test: IGRA, **submit lab report** Date: _____ Results: ☐ Negative ☐ Positive

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Section B: Chest X-Ray - If patient has a documented history of a positive TB test, a chest x-ray report must be submitted with this form. Chest X-Ray must be dated less than 3 months from the first day of classes

Date of Chest X-Ray: _____ Results: ☐ Negative ☐ Positive

Section C: Treatment for TB or LTBI - Documentation of treatment must be submitted with form

Date treatment started: _____ Date treatment completed: _____

Name of medication:_____

Healthcare Provider Signature: _____ **Contact Phone Number:** _____

Name of Practice:_____

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Student Name: _____ G # _____

PART 5. REQUIRED IMMUNIZATIONS - TO BE COMPLETED BY A HEALTHCARE PROVIDER WHO MUST ALSO COMPLETE AND SIGN PART 7. SHS will not accept "see attached" all dates must be written in. All titer reports must be submitted with the Immunization Record form for proper documentation.

TETANUS-DIPHTHERIA Must have a documented Tdap after age 11. Must have a TD booster within the past 10 years (no titers accepted).

Tdap within past 10 years AND **after age 11** _____ { **OR** } **Tdap after age 11** _____ AND **TD within past 10 years** _____

MEASLES, MUMPS, RUBELLA (MMR) **(1)** _____ **(2)** _____

2 doses of MMR 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 **TWO (2) DOSES OF EACH OF THE FOLLOWING VACCINES:**

Measles (Rubeola) **(1)** _____ **(2)** _____

Mumps **(1)** _____ **(2)** _____

Rubella (German Measles) **(1)** _____ **(2)** _____

OR ☐ Copy of titer lab work indicating **positive** immunity must be submitted with form

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

	(1) _____	**(2)** _____	**(3)** _____
Check One	☐ Hepatitis B ☐ Twinrix	☐ Hepatitis B ☐ Twinrix	☐ Hepatitis B ☐ Twinrix

OR ☐ Copy of titer lab work indicating **positive** immunity must be submitted with form **OR** ☐ signed waiver on part 8 of this form

MENINGOCCOCAL QUADRIVALENT (A, C, Y, W-135) _____ (most recent date) Administered between the ages of 16 and 21 Preferred, administered simultaneously with Tdap if possible.

OR ☐ signed waiver on part 8 of this form **OR** ☐ over 21 years of age (not required to show proof of vaccination)

PART 6. RECOMMENDED IMMUNIZATIONS - TO BE COMPLETED BY A HEALTHCARE PROVIDER WHO MUST ALSO COMPLETE AND SIGN PART 7. SHS will not accept "see attached" all dates must be written in. All titer reports must be submitted with the Immunization Record form for proper documentation.

VARICELLA (chicken pox) **(1)** _____ **(2)** _____ or titer report submitted with form

HUMAN PAPILLOMAVIRUS (HPV) **(1)** _____ **(2)** _____ **(3)** _____

Check One	☐ HPV 4 ☐ HPV 9	☐ HPV 4 ☐ HPV 9	☐ HPV 4 ☐ HPV 9

HEPATITIS A (If Twinrix, see Part 5, Hepatitis B) **(1)** _____ **(2)** _____ or titer report submitted with form

MENINGOCOCCAL TYPE B (not MCV ACYW) **(1)** _____ **(2)** _____ **(3)** _____ ☐ Bexsero ☐ Trumemba

Strongly recommended if living in a dorm or dormlike facility

PART 7. HEALTHCARE PROVIDER INFORMATION AND SIGNATURE, ALL INFORMATION REQUIRED

☐ Transcribed Records ☐ Administered Vaccine(s)

Printed Name and Title: _____

Name of Practice: _____

Clinic Address: _____ Phone Number: _____

Healthcare Provider Signature: _____ Date: _____

Student Name: _____ G # _____

PART 8: WAIVERS FOR HEPATITIS B AND MENINGOCOCCAL

WAIVER OF IMMUNIZATION AGAINST HEPATITIS B DISEASE
only if no previous record of vaccination

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	If student is a minor, Parent/Guardian Signature required also	Date
_____	_____	_____	_____

WAIVER OF IMMUNIZATION AGAINST MENINGOCOCCAL DISEASE
only if no previous record of vaccination

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	If student is a minor, Parent/Guardian Signature required also	Date
_____	_____	_____	_____