

# Certificate of Immunization

Student Legal Last Name (surname) \_\_\_\_\_ Student Legal First Name \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_  
Student ID (G)#: \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Mobile #: \_\_\_\_\_  
Start Date (Semester, Year): \_\_\_\_\_  
Enter Fall, Spring, Summer semester

Visit [shs.gmu.edu/immunizations](https://shs.gmu.edu/immunizations) for detailed instructions, FAQs, Immunization Office hours & info.

## Student Instructions

1. Download and print Certificate of Immunization. Complete student sections.
2. Take this form and supporting immunization documents to a healthcare provider. This form is required to be completed and signed by a healthcare professional.
3. Submit completed form and support documents by deadline listed online at [shs.gmu.edu/immunizations](https://shs.gmu.edu/immunizations).
4. Check compliance status in Patient Portal after submission & processing.  
Note: the Immunization Office will process submission. It can take between 7 – 14 business days.

## Requirements

- ALL students must complete Part 1: Tuberculosis (TB) Screening Questionnaire (page 2).
- ALL students born after 12/31/1956 must provide accepted proof of immunizations listed in Part 3 (page 4).
- Healthcare provider must complete and sign ('transcribe') Part 2\*, Part 3, and Part 4. (*\*if applicable*)
  - If you do not have a healthcare provider, you can complete the Transcription Consent below to have this service with Student Health Services for a fee.
- Student's legal name and date of birth must be on all document pages, titer lab reports, x-ray reports, and records.
- All support documents or records must be in English. If not in English, must provide certified translation.
- **A \$50 late fee & hold will be placed on the student account if the Certificate of Immunization & requirements are not deemed complete by the Student Health immunization staff by listed deadlines.**

## How to submit Certificate of Immunization and support documents

- **Preferred Method: Upload to the Patient Portal at <https://gmumedicatconnect.com>.** Scan or take photo of documents and save to your device. Follow instructions on Upload page in Portal.
- Or Mail to: George Mason University Student Health Services, 4400 University Drive, MS 2D3, Fairfax, VA 22030 (*Mailed forms must be received by deadline. Keep copies of documents.*)

## After submission – log into Patient Portal to check status

- Students will be notified regarding compliance or non-compliance. The student will get an email to their Mason email. It will state you have a secure message and should log into the Patient Portal. These messages may go to spam/junk. Go to Messages in the Portal to review compliance status.

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

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**Transcription Service Consent:** Info on [Transcription Service](https://shs.gmu.edu/immunizations/transcription-service) visit [shs.gmu.edu/immunizations/transcription-service](https://shs.gmu.edu/immunizations/transcription-service). Upload completed student sections of the Certificate of Immunization & support documents to Portal for service.

Yes, I request transcription service with Student Health. I agree to pay the \$20 fee. (Do not prepay.) **Must sign below.**  
No, I do not want transcription service. (Do not sign.)

Student/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Name: \_\_\_\_\_

G#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PART 1: TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

**Instructions:** Questionnaire required for all students. Student must answer ALL questions below & sign. Blue or black ink only. List countries where indicated. Select Yes or No for response to questions 2 – 8.

1. List the country where you were born: \_\_\_\_\_

2. Have you ever tested positive for TB (tuberculosis)?  Yes  No

**If yes:** healthcare provider must complete Part 2. Student must provide documentation of a positive TB test (historical or current) and documentation of a chest x-ray dated within 3 months of classes starting.

**If no:** go to question 3.

3. Have you ever lived or traveled in any country other than the United States for more than a month at a time?  Yes  No

List the countries you have you lived in: \_\_\_\_\_

List the countries you have you traveled to: \_\_\_\_\_

4. Do you have an immuno-suppressive disease?  Yes  No

Persons who are receiving immune-suppressive medications such as corticosteroid or drug therapy following organ transplantation and persons with immune-suppressive conditions such as HIV, diabetes mellitus, chronic renal failure, leukemia, or cancer.

5. Have you had close contact with anyone who is or was sick with TB?  Yes  No

6. Have you resided in, volunteered or worked in a prison, nursing home, hospital, or homeless shelter?  Yes  No

7. Do you have any symptoms of active TB, such as a cough longer than 3 weeks, night sweats, fever, unexplained weight loss and/or fatigue?  Yes  No

Student/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you were not born in the United States of America OR if you answer "Yes" to any of the above questions a healthcare provider must complete Part 2: Assessment & Tuberculosis Testing by a healthcare provider on page 3.

Student Name: \_\_\_\_\_

G#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PART 2: ASSESSMENT & TUBERCULOSIS TESTING BY A HEALTHCARE PROVIDER

- Review Part 1: TB Screening Questionnaire. Answer questions 1 and 2 below.
- Provide copies of reports as specified below. Reports must be in English and include patient's full name and date of birth.
- TB tests (if not historical) and/or chest x-ray (if required) must be within 3 months of class start date - dated after May 1<sup>st</sup> of the current year for Fall enrollment and October 1<sup>st</sup> of previous year for Spring enrollment. Testing completed too early or with invalid results may require repeat testing.
- Student should upload documentation to Mason's Health Services Patient Portal.

1. Patient history of BCG?  No  Yes
2. Result of TB risk assessment completed by provider  Low risk. No testing needed.  
 High risk. Proceed to testing (**go to 3a**).

### 3a. Patient does NOT have a history of POSITIVE IGRA (QFT or T-spot) or Tuberculin Skin Test (TST)

*Student must receive either an IGRA or TST within 3 months of classes start date.*

**QFT or T-SPOT Interferon Gamma Release Assay (IGRA)** - Test must be within 3 months of classes start date. QFT or T-spot IGRA completed  No  Yes

**\*\*Give lab report to patient for upload to the Health Services Patient Portal**

Based on IGRA result, does patient need a chest x-ray?  No  Yes (go to 3b)

**TUBERCULIN SKIN TEST (TST)** - TST result must be recorded in millimeters [mm] of induration, transverse diameter; if no induration, write "0." The TST interpretation is based on induration and risk factors.\*\* Test must be within 3 months of classes start date.

Results in mm of induration: \_\_\_\_\_ Date Placed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

**\*\*Interpretation:**  Positive (**go to 3b**)  Negative

### 3b. Patient has a history of POSITIVE IGRA (QFT or T-spot) or Tuberculin Skin Test (TST). **Proceed to 4.**

*Student must provide copy of historical positive results and have a chest x-ray within 3 months of classes start date.*

### 4. CHEST X-RAY: REQUIRED IF DOCUMENTATION OF POSITIVE IGRA OR TST.

Must provide a copy of the chest x-ray report dated after May 1<sup>st</sup> of the current year for Fall enrollment and October 1<sup>st</sup> of previous year for Spring enrollment. Must include patient's full name and date of birth.

5. Has the patient been treated for:  TB Infection (LTBI)  TB Disease

Has the patient completed treatment?  No  Yes

List Medication(s): \_\_\_\_\_

Date Began Medication: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Medication completed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

All students with a positive IGRA or TST and no signs of active disease on chest x-ray should receive education and treatment recommendations for Latent Tuberculosis Infection (LTBI). LTBI must be reported to local health department.

Further information for [Virginia TB](http://www.vdh.virginia.gov/tuberculosis/), visit [vdh.virginia.gov/tuberculosis/](http://www.vdh.virginia.gov/tuberculosis/)

**This form will not be accepted if not signed by a healthcare provider (MD, DO, NP, PA, Nurse). Use stamp for facility information.**

Provider Printed Name and Credentials: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_

Healthcare Facility Stamp:  
(or write in Facility Name,  
Address)

Student Name: \_\_\_\_\_

G#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### PART 3: REQUIRED IMMUNIZATIONS

- A Healthcare Provider (MD, DO, NP, PA, Nurse) must complete & sign form in blue or black ink. "See attached" is not acceptable documentation. All dates must be entered onto form (check marks not acceptable).
- Provide copies of titer reports. Must be in English. Must include patient's full name and date of birth.
- Student should upload to the Health Services Patient Portal.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| <b>Hepatitis B</b> - Must receive a complete series, or attach positive titer, or sign waiver<br>____ Hepatitis B ____ Twinrix ____ Heplisav | Date<br>____/____/____<br>(MM/DD/YYYY)  | Date<br>____/____/____<br>(MM/DD/YYYY)  | Date<br>____/____/____<br>(MM/DD/YYYY)               | <input type="checkbox"/> OR Titer Report of Immunity | <input type="checkbox"/> OR Waiver pg. 5 |
| <b>Measles, Mumps, Rubella (MMR)</b>   | Dose must be after 1 <sup>st</sup> birthday<br>____/____/____<br>(MM/DD/YYYY) | 2 <sup>nd</sup> dose at least 28 days later<br>____/____/____<br>(MM/DD/YYYY) | <input type="checkbox"/> OR Titer Report of Immunity |  |  |
| <b>OR Individual Measles</b> - 2 doses at least 1 month apart  | ____/____/____<br>(MM/DD/YYYY)  | ____/____/____<br>(MM/DD/YYYY)  | <input type="checkbox"/> OR Titer Report of Immunity |  |  |
| <b>OR Individual Mumps</b> - 2 doses at least 1 month apart  | ____/____/____<br>(MM/DD/YYYY)  | ____/____/____<br>(MM/DD/YYYY)  | <input type="checkbox"/> OR Titer Report of Immunity |  |  |
| <b>OR Individual Rubella</b> - 1 dose  | ____/____/____<br>(MM/DD/YYYY)  | <input type="checkbox"/> OR Titer Report of Immunity                          |  |  |  |
| <b>Meningococcal Vaccine (ACWY)</b><br>Given on or after age 16, or student over age 21, or sign waiver<br>____ ACWY ____ ABCWY              | ____/____/____<br>(MM/DD/YYYY)  | ____/____/____<br>(MM/DD/YYYY)  | <input type="checkbox"/> Patient aged 21 or older    | <input type="checkbox"/> OR Waiver pg. 5             |  |
| <b>Poliomyelitis</b><br>Last dose on or after age 4. Titer not accepted.   | Date of last dose ____/____/____ ____OPV ____IPV<br>(MM/DD/YYYY)              |   |  |  |  |
| <b>Tetanus, Diphtheria vaccine</b><br>Within past 10 years.  | ____/____/____ ____Td ____Tdap<br>(MM/DD/YYYY)                                |   |  |  |  |

### PART 4: STRONGLY RECOMMENDED BUT NOT REQUIRED IMMUNIZATIONS

|  |  |  |  |
|--|--|--|--|
| <b>COVID-19</b><br>List Manufacturer (ex: Pfizer, Moderna)   | ____/____/____<br>(MM/DD/YYYY)<br>Mfr: _____ | ____/____/____<br>(MM/DD/YYYY)<br>Mfr: _____ | ____/____/____<br>(MM/DD/YYYY)<br>Mfr: _____ |
| <b>Hepatitis A</b>   | ____/____/____<br>(MM/DD/YYYY)               | ____/____/____<br>(MM/DD/YYYY)               | <input type="checkbox"/> Titer Report        |
| <b>Human Papilloma Virus</b><br>____ HPV4 ____ HPV9          | ____/____/____<br>(MM/DD/YYYY)               | ____/____/____<br>(MM/DD/YYYY)               | ____/____/____<br>(MM/DD/YYYY)               |
| <b>Influenza</b> (most recent)                               | ____/____/____<br>(MM/DD/YYYY)               |  |  |
| <b>Meningococcal B Vaccine</b><br>____ Bexsero ____ Trumenba | ____/____/____<br>(MM/DD/YYYY)               | ____/____/____<br>(MM/DD/YYYY)               | ____/____/____<br>(MM/DD/YYYY)               |
| <b>Varicella</b>   | ____/____/____<br>(MM/DD/YYYY)               | ____/____/____<br>(MM/DD/YYYY)               | <input type="checkbox"/> Titer Report        |

**This form will not be accepted if not signed by a healthcare provider (MD, DO, NP, PA, Nurse). Use stamp for facility information.**

Provider Printed Name and Credentials: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_

Healthcare Facility Stamp:  
(or write in Facility Name,  
Address)

Student Name: \_\_\_\_\_

G#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PART 5: MINOR CONSENT, WAIVERS, AND EXEMPTIONS (if applicable)

### INSTRUCTIONS:

- Complete applicable sections.
- Student, or parent/guardian if student is a minor, sign applicable sections. Use blue or black ink.
- Student should upload to Health Services Patient Portal.

### Minor Consent - Requested if student is 17 or younger

Parental permission or the consent of a legal guardian must be obtained to provide medical or surgical care for minors. To avoid delays in treatment in the event of an illness or accident, please obtain the signature of a parent/legal guardian if you are 17 or younger at the time of submission.

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: \_\_\_\_\_

PRINT Parent/Guardian Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

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### Hepatitis B Vaccine Waiver

Read CDC website [Hepatitis B information: cdc.gov/vaccines/vpd/hepb](https://www.cdc.gov/vaccines/vpd/hepb)

I have read and reviewed information on the risk associated with hepatitis B disease, availability, and effectiveness of any vaccine against hepatitis B disease and I choose not to be vaccinated against hepatitis B disease.

\_\_\_\_\_  
Signature of Student or Parent/Guardian

\_\_\_\_\_  
Date

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### Meningococcal Vaccine Waiver

Read CDC website [Meningococcal information: cdc.gov/meningococcal/](https://www.cdc.gov/meningococcal/)

I have read and reviewed information on the risk associated with meningococcal disease, availability, and effectiveness of any vaccine against meningococcal disease and I choose not to be vaccinated against meningococcal disease.

\_\_\_\_\_  
Signature of Student or Parent/Guardian

\_\_\_\_\_  
Date

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### Religious Exemption

**Tuberculosis screening required regardless of exemption.**

Any student who objects on the grounds that administration of immunizing agents conflicts with their religious tenets or practices shall be exempt from the immunization requirements unless an emergency or epidemic of disease has been declared by the Board of Health.

A sworn statement of religious exemption must be submitted on the George Mason University *Certificate of Religious Exemption* Form found on the [Student Health Services website at shs.gmu.edu/about/forms](https://shs.gmu.edu/about/forms).

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### Medical Exemption

**Tuberculosis screening required regardless of exemption.**

Any student who has a medical contraindication that prevents vaccination must have a licensed physician complete and sign the Medical Exemption Form found on the [Student Health Services website at shs.gmu.edu/about/forms](https://shs.gmu.edu/about/forms).