



CLARK ATLANTA UNIVERSITY
STUDENT HEALTH SERVICES CENTER



IMMUNIZATION/TUBERCULOSIS SCREENING RECORD

Name: _____ DOB ___/___/___ Social Security: _____ - _____ - _____
Year of Enrollment _____

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

A. TETANUS-DIPHTHERIA (REQUIRED) _____ month/day/year

1. Tetanus-Diphtheria booster (must be within last ten years) _____/_____/_____

B. MMR (two doses required) – OR – MMR (one dose) and separate Rubella (one dose)

MMR:

- 1. Dose 1 given 12-months after birth (or later) and Dose 2 after 1980
 - a. Dose 1 – specify date. _____/_____/_____
 - b. Dose 2 – specify date. _____/_____/_____

Rubella:

- 1. Had vaccine. Specify date. _____/_____/_____
- 2. Has report of positive immune titer. Specify date. _____/_____/_____
- 3. Had disease confirmed by doctor's records (attach copy)
- 4. Born before 1957 and therefore considered immune.

Mumps:

- 1. Had vaccine. Specify date.
- 2. Has report of positive titer. Specify date. _____/_____/_____
- 3. Had disease confirmed by doctor's record. (attach copy) _____/_____/_____
- 4. Born before 1957 and therefore considered immune.

Measles:

- 1. Had vaccine. Specify date. _____/_____/_____
- 2. Has report of positive titer. Specify date. _____/_____/_____
- 3. Had disease confirmed by doctor's record. (attach copy)
- 4. Born before 1957 and therefore considered immune.

C. Menomune-A/C/Y/W-135 (Meningitis) (REQUIRED) _____/_____/_____

D. Additionally, the following vaccines are strongly recommended for all students.

- 1. Varicella _____/_____/_____
- 2. Hepatitis B _____/_____/_____
- 3. Influenza _____/_____/_____

Name _____ DOB: ___/___/___ Last 4 of SS#: _____

E. TUBERCULOSIS SCREENING/TESTING (REQUIRED) _____ month/day/year

1. PPD (Mantoux) within the past year (tine not acceptable)
Date (Placement): _____ Site of placement : _____
Result: _____ mm induration (horizontal diameter) Read by: _____ Date: ___/___/___

2. If previous positive PPD or new PPD greater than 5mm induration, chest x-ray required.
X-ray result: Normal Abnormal _____/___/___

3. Received BCG: Yes No If yes, chest x-ray required. Normal Abnormal _____/___/___

4. INH treatment or other TB prophylaxis treatment completed (provide documentation).
Chest X-ray required (within past 6 months)

F. Exemption on grounds of permanent medical contraindication.

Exemption on grounds of temporary medical contraindication.

Pregnancy - expected date of end of confinement. _____/___/___

Other - anticipated date of end of contraindication. _____/___/___

G. Religious Exemption

I affirm that immunization as required by Clark Atlanta University is on conflict with my religious beliefs. I understand that I am subject to exclusion in the event of a disease for which immunization is required.
PLEASE NOTARIZE.

Student Signature Date

Notary Public Date

NOTICE: Permission is hereby granted for Clark Atlanta university Health Services medical staff and/or their consultants to carry out indicated medical and surgical treatment. Major surgery or illness causes are transferred to other Atlanta area hospitals. Permission will be sought by the hospital and attending private physician prior to surgery and/or treatment.

Signature of Student or Parent (if student is under the age of 18) Date

HEALTH CARE PROVIDER (Please Stamp)

Name _____ Address _____

Signature _____ Phone (____) _____

PLEASE RETURN COMPLETED FORM TO: Student Health Services
Clark Atlanta University
223 James P. Brawley Drive
Atlanta, GA 30314