Student Health Services
Immunization/ Tuberculosis Screening Record

PART I

Name ____________________________ ____________________________ Telephone Number ____________________________

Address ____________________________ ____________________________ ____________________________ ______________

Street City State Zip ____________________________ ____________________________ ____________________________

Date of Enrollment __/____/________ Date of Birth __/____/________ School ID# ____________________________

M Y M D Y

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate _____

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA) (Required)
(Two doses required at least 28 days apart for students born after 1956.)

1. Dose 1 given at age 12 months or later ................................................................. #1 __/____/________

M Y

2. Dose 2 given at least 28 days after first dose ................................................................. #2 __/____/________

M Y

OR positive antibody titer (blood test) lab report required

B. MENINGOCOCCAL QUADRIVALENT (Required) Polysaccharide acceptable
(A, C, Y, W-135) 2 doses; 2nd dose to be given after age 16

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1 __/____/________ b. Dose #2 __/____/________

M D Y M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).
   Date __/____/________

M D Y

C. TETANUS, DIPHTHERIA, PERTUSSIS (Required) (Must be within the last ten years)

Date of most recent booster dose: __/____/________ Type of booster: Td _____ Tdap _____
M D Y Tdap booster recommended for ages 11-64 unless contraindicated

Must remain current throughout matriculation.

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

1. Varicella: __/____/____: __/____/____

M D Y M D Y

2. Hepatitis A: __/____/____: __/____/____

M D Y M D Y

3. Hepatitis B: __/____/____: __/____/____: __/____/____

M D Y M D Y M D Y

4. Influenza: __/____/____

M D Y

5. Meningitis B: __/____/____: __/____/____

M D Y M D Y

Rev. 12/2020
E. TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by health care provider)

**Tuberculin Skin Test (TST) (Required within past 12 months)**
(The TST interpretation should be based on mm of induration as well as risk factors.)

Date Given: ____/____/____
Date Read: ____/____/____

Result: ______ mm of induration (Must be numerical) If no duration, write “0”.
An induration 10mm or above requires a chest x-ray

**Interpretation: Negative___ Positive ___**

Interferon Gamma Release Assay (IGRA): (specify method) QFT-GIT   T-Spot   other____

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Chest x-ray: (Required if TST induration is 10mm or above or IGRA is positive)

Date of chest x-ray: ____/____/____
Result: normal____ abnormal____

F. Medical Exemption: (Attach Verification by Healthcare Provider)

☐ Exemption on grounds of permanent medical contraindication

☐ Exemption on grounds of temporary medical contraindication- Expected end date ___/___/____

G. Religious Exemption:

☐ I affirm that immunizations as required by Clark Atlanta University are 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.
   (Attach Notarized Affidavit)

Notice: Permission is hereby granted for Clark Atlanta University Health Services staff and/or their consultants to carry out indication medical and surgical treatment. Major surgery or illness cases 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

Name __________________________________________ Signature __________________________________ Date __________________________
Address __________________________________________ Phone (__________) __________________________

Input immunization dates and upload completed form to cau.medicalconnect.com
Contact our office at (404)880-8322 if you have any issues

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