

Student Health Services Immunization/Tuberculosis Screening Record

PART I

Name					
Last, First, M.I		Telephone Number			
Address					
Street		City		State	Zip
Date of Enrollment/ Date of Birth/	/ D Y	School ID# _			
Status: Part-time Full-time Gra	_	_ Undergraduate _			
PART II: TO BE COMPLETED, STAMPED A	D SIGN	ED BY YOUR HE	ALTH CAR	E PROVID	ER.
All information must be in English.					
A. MMR (MEASLES, MUMPS, RUBELLA) (R	auired)				
Two doses required at least 28 days apart for st	dents born	after 1956.			
Dose 1 given at age 12 months or later.			. #1//		
Dose 2 given at least 28 days after first dose			. #2 <u>/</u> / M D	Y	
OR Positive antibody titer (blood test) lab report requ	red.				
B. MENINGOCOCCAL QUADRIVALENT (Re	quired)				
MenACWY or Conjugate 2 doses; 2 nd dose to be §		•			
Dose #1 / / Dose	#2/	<u>/</u>			
MENINGOCOCCAL B (Bexero, Trumenb					
Date / / M D Y					
C. TETANUS, DIPHTHERIA, PERTUSSIS (Re	quired)				
Must be within the last ten years and remain curre	t througho	out matriculation.			
Date of most recent booster dose: / / M D Y		Type of booster: Tdap booster reco			ss contraindicated
D. HEPATITIS B Series (Required)					
a. Dose #1 / / b. Dose #2 M	D Y	c. Dose #3	/ / D Y	_	
OR Hepatitis B titers: Date performed: / / M D Y	_	Results: Lab repo	ort required		<u> </u>
$\textbf{E. VARICELLA Vaccine} \ (\textbf{Required} \) \ \textbf{Historical}$	eport not	acceptable without	titer		
1st dose given at age 12 months or later.					
a. Dose #1 / / b. Dose #2 M	D Y	<u> </u>			
OR Positive titers: Date drawn: / / M D Y	_	Results: Lab repo	ort required		
F. COVID-19 Bivalent Vaccine (Required)					
COVID-19 Bivalent: Choose vaccine name- Moderna	Pfize	r or other	WHO approved	vaccine	
Date of Bivalent dose: / / / M D Y					
Covid-19 EXEMPTION: In order to waive the COVID-19	accine rec	uirement von must do	wnload the wei	ver form links	ed on the login

page of Point and Click Patient Portal and attach to this document.

Name	e: School ID#
G. 7	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: / / Time:
	Date Read: / / Time: M D Y
	Result:mm of induration (Must be numerical) If no induration, write "0". An induration 10mm or above requires a chest x-ray
	**Interpretation: Negative Positive
	Interferon Gamma Release Assay (IGRA): (specify method and attach report) QFT-GIT T-Spot other
	Result: negative positive indeterminate borderline(T-Spot only)
	Chest x-ray (Attach Report): (Required if TST induration is 10mm or above or IGRA is positive)
	Date of chest x-ray: / / Result: normal abnormal abnormal
	Medical Exemption: (Attach Verification by Healthcare Provider) ☐ Exemption on grounds of permanent medical contraindication
	☐ Exemption on grounds of temporary medical contraindication-Expected end date / / / M D Y
	Religious Exemption:
	☐ I affirm that immunizations as required by Clark Atlanta University are on conflict with my religious beliefs. It understand that I am subject to exclusion in the event of a disease for which immunization is required. (Attach Notarized Affidavit)
to c Atla	tice: Permission is hereby granted for Clark Atlanta University Health Services staff and/or their consultants carry out indication medical and surgical treatment. Major surgery or illness cases are transferred to other anta area hospitals. Permission will be sought by the hospital and attending private physician prior to surgery l/or treatment.
Sig	gnature of Student or Parent (If student is under the age of 18) Date
HI	EALTH CARE PROVIDER
Naı	meSignatureDate
Ado	Phone ()
	Toward in constitution datas and unlead consulated forms to
	Input immunization dates and upload completed form to Point and Click Patient Portal
	Contact our office at (404)756-1241 or (404)880-8322
	if you have any issues
	$oldsymbol{arphi}$