



AUCC Immunization Form
 Student Health and Wellness Center
 455 Lee St SW, Suite 300 A, Atlanta, GA 30310
 (404) 756-1241 shwcrequests@msm.edu
https://www.msm.edu/Current_Students/student-health/

Name: _____ DOB: ____/____/____

Circle Your School: Morehouse School of Medicine Clark Atlanta University Morehouse College

Student ID#: _____ School Email: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Instructions:

- This form **must** be completed by a healthcare provider and stamped by the office. **No exceptions.**
- Retain a copy of the completed form for your records.
- Scan this QR code for instructions on how to access your portal and upload the information.
- Upload a copy of this completed form to your Point and Click Patient Portal.



REQUIRED IMMUNIZATIONS

Required Immunizations	Date Administered (MM/DD/YYYY)	Required For
MMR (Measles, Mumps, and Rubella)	1 st Dose ____/____/____ 2 nd Dose ____/____/____ OR attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	Students born in 1957 or later and all foreign-born students, regardless of year born. If a titer is performed and does not indicate immunity a subsequent injection series is required. Antibody titer report must be submitted on lab letter head from a certified laboratory.
Varicella (Chicken Pox)	1 st Dose ____/____/____ 2 nd Dose ____/____/____ OR attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	All U.S. born citizens born in 1980 or later and all foreign-born students regardless of year born. If a titer is performed and does not indicate immunity a subsequent injection series is required. Antibody titer report must be submitted on lab letter head from a certified laboratory.
TDAP	Received within the last 10 years ____/____/____	One dose of TDAP received within the last 10 years.



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<p>Hepatitis B (check box below)</p> <p><input type="checkbox"/> 2 dose series</p> <p><input type="checkbox"/> 3 dose series</p> <p><input type="checkbox"/> Hep A – Hep B Twinrix</p>	<p>Either 2 dose series or 3 dose series</p> <p>1st Dose ___/___/___</p> <p>2nd Dose ___/___/___</p> <p>3rd Dose ___/___/___</p> <p>OR attached antibody titers</p> <p>**You do not need to submit antibody titers if you submit immunization records.</p>	<p>If a titer is performed and does not indicate immunity a subsequent injection series is required.</p> <p>Antibody titer report must be submitted on lab letter head from a certified laboratory.</p>
<p>Meningococcal MCV4/ Meningococcal ACWY/ Meningococcal Conjugate</p>	<p>One dose received on or after your 16th birthday.</p> <p>___/___/___</p>	<p>For all students 21 years old or younger and any student living in the dormitories.</p> <p>If your last dose was received >5 years ago, a booster dose is recommended. Please discuss with your health care provider.</p> <p><input type="checkbox"/> I attest that I am a graduate student living off campus.</p>
<p>Meningococcal B (check box below)</p> <p><input type="checkbox"/> 2 dose series Bexsero</p> <p><input type="checkbox"/> 3 dose series Trumenba</p>	<p>Either 2 dose series or 3 dose series</p> <p>1st Dose ___/___/___</p> <p>2nd Dose ___/___/___</p> <p>3rd Dose ___/___/___</p>	<p>Required for individuals living in dorms/apartments and those younger than 23 years of age.</p> <p>Recommended for graduate students living off campus.</p> <p><input type="checkbox"/> I attest that I am a graduate student living off campus.</p>
<p>COVID-19 (check box below)</p> <p><input type="checkbox"/> Bivalent vaccine</p> <p><input type="checkbox"/> Updated Pfizer vaccine</p> <p><input type="checkbox"/> Updated Moderna Vaccine</p> <p><input type="checkbox"/> Novavax vaccine</p>	<p>Vaccine must have been given on or after 8/31/22 or later to be approved.</p> <p>1st Dose ___/___/___</p> <p>2nd Dose ___/___/___</p>	<p>Requirement satisfied by either the bivalent COVID 19 vaccine, 1 dose of the updated Pfizer vaccine, 1 dose of the updated Moderna vaccine, or 2 doses of Novavax vaccine are required for approval. Any vaccines given before 8/31/22 will not meet the requirement.</p>

Signature of Health Care Provider and Date Required	
<p>Name:</p> <p>Signature:</p> <p>Address:</p> <p>Phone Number:</p> <p>Date:</p>	



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RECOMMENDED IMMUNIZATIONS

Recommended Vaccines	Date Administered (MM/DD/YYYY)	Recommended For
Hepatitis A (check box below) <input type="checkbox"/> 2 dose series <input type="checkbox"/> 3 dose series	Either 2 dose series or 3 dose series 1 st Dose ___/___/_____ 2 nd Dose ___/___/_____ 3 rd Dose ___/___/_____ _____	Recommended for individuals with chronic liver disease, HIV infection, men who have sex with men, injection drug use, those working with Hepatitis A virus, who travel to countries with high prevalence countries, pregnancy, and settings for exposure.
Influenza Annually	Dose from most recent season ___/___/_____ _____	All individuals residing in dormitories or other group living situations, or who are members of athletic teams. Individuals with asthma, diabetes, or an immunodeficiency.
Human Papillomavirus (check box below) <input type="checkbox"/> 2 dose series <input type="checkbox"/> 3 dose series	Either 2 dose series or 3 dose series 1 st Dose ___/___/_____ 2 nd Dose ___/___/_____ 3 rd Dose ___/___/_____ _____	Strongly recommended for all unvaccinated males and females through age 26.

Signature of Health Care Provider and Date Required

Name:
Signature:
Address:
Phone Number:
Date:

