



AUCS Immunization Form
 Student Health and Wellness Center
 455 Lee St SW, Suite 300A, Atlanta, GA 30310
 (404) - 756 - 1241

https://www.msm.edu/Current_Students/student-health/

Name: _____ DOB: ____/____/____

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

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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Wellness Center**

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Name: _____

<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"/> 2 dose series Trumenba</p>	<p>2 dose series</p> <p>1st Dose ___/___/___</p> <p>2nd 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>

Signature of Health Care Provider and Date Required	
<p>Name:</p> <p>Signature:</p> <p>Address:</p> <p>Phone Number:</p> <p>Date:</p>	<p style="font-size: 2em; opacity: 0.5;">Office Stamp Required</p>



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 immunodeficiency. ALL MSM STUDENTS ARE REQUIRED TO RECEIVE UPDATED INFLUENZA VACCINE EVERY FALL
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.
COVID-19 (check box below) <input type="checkbox"/> Bivalent vaccine <input type="checkbox"/> Updated Pfizer vaccine <input type="checkbox"/> Updated Moderna Vaccine <input type="checkbox"/> Novavax vaccine	Either 1 dose series or 2 dose series 1 st Dose ___/___/___ 2 nd Dose ___/___/___	Strongly recommended for all persons aged ≥6 months to protect from severe disease, hospitalization, and death. MSM clinical students are required to receive a COVID vaccine since September 2022

Signature of Health Care Provider and Date Required	
Name: Signature: Address: Phone Number: Date:	<div style="font-size: 2em; opacity: 0.5; font-family: cursive;">Office Stamp Required</div>



Student ID #: _____

Name: _____

TUBERCULOSIS TESTING FORM

Tuberculosis testing is required for all students attending Clark Atlanta University, Morehouse College University, and students in clinical programs at Morehouse School of Medicine. Students in clinical programs at Morehouse School of Medicine **MUST** have an IGRA test or Chest X-ray. **There are no exemptions allowed for tuberculosis testing.**

A.	<p>TST (Tuberculin Skin Test)</p> <p>If the test result is positive, please complete section C.</p> <p>TST must be completed no more than twelve months prior to the start of classes within the U.S or Canada</p> <p>Date placed: _____ Date Read: _____ Result: _____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative</p> <p>A PPD/TST of ≥ 5 mm induration is considered positive for immunosuppressed students. A PPD/TST of ≥ 10 mm induration is considered positive for individuals with risk of exposure to TB. A PPD/TST of ≥ 15 mm induration is considered positive for students with no risk factors.</p>
B.	<p>IGRA (Interferon Gamma Release Assay) Blood Test – may be completed as an alternative to section A.</p> <p>If the test result is positive, please complete section C.</p> <p>Please attach lab report in English.</p> <p>IGRA = Quantiferon or T-Spot. If indeterminate or borderline results are received, repeat the test, or perform a chest x-ray in the United States or Canada</p>
C.	<p>Chest X-ray - only if section A or B is positive.</p> <p>Please attach x-ray report.</p> <p>Chest x-ray must be completed in the US/Canada only and must be completed no more than twelve months prior to the start of classes.</p>
D.	<p>If you have a history of tuberculosis disease, please provide written documentation of treatment and clearance from your healthcare provider.</p>

Signature of Health Care Provider and Date Required

Name: _____
Signature: _____
Address: _____
Phone Number: _____
Date: _____

Office Stamp Required