CERTIFICATE OF REQUIRED IMMUNIZATIONS

Immunizations Department – Office of the Registrar

email: immunizationsvc@kennesaw.edu

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS

Semester: _____ **Country of Birth:** _____

KSU ID#: 000_____ Cell Phone #:_____ Email: _____

Name (Last, First, Middle) _____

Address:_____ City:_____ State: _____ Country: _____

Zip Code:_____ **Birth Date:** _____

REQUIRED IMMUNIZATIONS	REQUIREMENT (MM/DD/YYYY)	REQUIRED FOR:
MMR (Measles, Mumps, Rubella) **OR**	#1 _____ #2 _____	• All foreign born students regardless of year born • US/Canadian students born in 1957 or later • 1st due at 12 months of age or older • 2nd dose administered no earlier than 28 days after 1st dose
• Measles (Rubeola) **AND** • Mumps **AND** • Rubella (German Measles)	#1_____#2 _____ **OR** Attached antibody titer (blood test) lab report **AND** #1_____#2 _____ **OR** Attached antibody titer (blood test) lab report **AND** #1 _____ **OR** Attached antibody titer (blood test) lab report.	• US/Canadian students born in 1957 or later • If Antibody titer does not indicate immunity, injection series required. • **You must submit the antibody titer report on lab letterhead from a certified lab with definitive lab values in English.** • 1st due at 12 months of age or older • 2nd dose administered no earlier than 28 days after 1st dose
Varicella (Chicken Pox)	#1_____#2 _____ **Or** Attached antibody titer (blood test) lab report **Or** Definitive diagnosis of varicella by healthcare provider (history of disease reported to provider not sufficient). Provide statement from provider verifying previous infection.	• **SELF/PARENTAL REPORTED HISTORY OF DISEASE NOT ACCEPTED** • All foreign born students regardless of year born. • US/Canadian born students born during or after 1980. • 1st due at 12 months of age or older • 2nd dose administered no earlier than 28 days after 1st dose • If Antibody titer does not indicate immunity, injection series required. • **You must submit the antibody titer report on lab letterhead from a certified lab with definitive lab values in English.**
Tetanus, Diphtheria, Pertussis (Tdap)	Tdap_____**(REQUIRED)**	• One dose of Tdap for all students. Preferably administered after 11th birthday. Must be administered after June 10, 2005.
Hepatitis B OR **Hep A-Hep B (Twinrix)**	#1 _____ #2 _____ #3 _____ **OR** Attached antibody titer (blood test) lab report	• All Students who will be 18 or younger on the first day of class. • If Antibody titer does not indicate immunity, injection series required. • **You must submit the antibody titer report on lab letterhead from a certified lab with definitive lab values in English.**
Meningococcal	Menactra or Menveo _____ (MCV4) **Or** Menactra or Menveo _____ Booster (MCV4)	• All students living in in KSU Campus Housing • **NOTE**: A student may sign a statement of understanding in lieu of providing proof of immunization. • **NOTE**: It is **strongly** recommended for all students under the age of 22.
Tuberculosis (TB)	All students **MUST** complete the **Tuberculosis Screening Questionnaire** found on page 2.	• If the answer to any of the TB screening questions is YES, then the TB skin test or IGRA needs to be completed by a physician.

CERTIFICATION OF HEALTHCARE PROVIDER

Name: _____

Signature: _____

Phone: _____ **Date:** _____

Physician Office Stamp

Effective Date of Revision 10/12/15

KENNESAW STATE UNIVERSITY

CERTIFICATE OF REQUIRED IMMUNIZATIONS

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Semester: _____ Country of Birth: _____ Birth Date: _____

KSUID#: _____ Name (Last, First, Middle): _____

Address: _____Cell Phone #: _____ Email: _____

TUBERCULOSIS RISK ASSESSMENT – TO BE COMPLETED BY A HEALTHCARE PROVIDER

Tuberculosis (TB) Screening Questions:

1.	Has the student ever had a positive TB skin Test?	Yes	No
2.	Has the student ever had close contact with somebody ill with TB?	Yes	No
3.	Was the student born in Africa, East Europe, Asia, Middle East, or South/Central America?	Yes	No
4.	Has the student traveled or lived more than six weeks in the areas listed above?	Yes	No
5.	Has the student been vaccinated with BCG?	Yes	No
6.	Has the student been an employee or volunteer in a prison, nursing home, Homeless shelter or hospital?	Yes	No
7.	Is the student on medications that suppress the immune system?	Yes	No
8.	Does the student have HIV?	Yes	No

If the answer to all of the above TB screening questions is No, then the student DOES NOT need a TB skin test or IGRA.
IF the answer to any of the previous TB screening questions is YES, then the student needs a TB skin test or IGRA.

Required Tuberculosis Screening

- History of (+) PPD or IGRA (circle one)?

□Yes, hx of + PPD of IGRA Date:_____/____/_____ (_____mm induration if PPD**)

- Treatment completed? □Yes, date:_____/____/_____ □No
- If + PPD or IGRA, chest x-ray required within the last 3 months:
  Date:_____/____/_____ □ Normal □ Abnormal

□No past hx of + PPD or IGRA:

- IGRA or PPD (circle one) required within the last 3 months, regardless of BCG history:

Date:____/____/_____

IGRA □Pos □Neg

OR

PPD □Pos □Neg _____mm induration**

- Newly documented positives also require chest-x-ray within the last 3 months:
  Date:_____/____/_____ □ Normal □ Abnormal

□ Treatment started? □ Yes, Date:____/___/_____ □ No

	***PPD Interpretation Guidelines	
> 5 mm is positive: • **Recent close contact with person with active TB** • **Abnormal CXR c/w past TB disease** • **Organ transplant or other immunosuppression HIV/AIDS**	**>10 mm is positive:** • **Significant travel or residence in high prevalence area** • **Illicit drug use** • **Worker in healthcare, homeless shelter, prisons** • **Chronic Health Issues, as per above screening questions**	**>15 mm is positive if no risk factors**

SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED

Name: _____

Signature: _____

Phone: _____ **Date:** _____

PHYSICAN OFFICE STAMP