



**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) <b>OR</b>	#1 _____ #2 _____	<ul style="list-style-type: none"> <li>All foreign born students regardless of year born</li> <li>US/Canadian students born in 1957 or later</li> <li>1<sup>st</sup> due at 12 months of age or older</li> <li>2<sup>nd</sup> dose administered no earlier than 28 days after 1<sup>st</sup> dose</li> </ul>
<ul style="list-style-type: none"> <li>Measles (Rubeola)</li> </ul> <b>AND</b> <ul style="list-style-type: none"> <li>Mumps</li> </ul> <b>AND</b> <ul style="list-style-type: none"> <li>Rubella (German Measles)</li> </ul>	#1 _____ #2 _____ <b>OR</b> Attached antibody titer (blood test) lab report <b>AND</b> #1 _____ #2 _____ <b>OR</b> Attached antibody titer (blood test) lab report <b>AND</b> #1 _____ <b>OR</b> Attached antibody titer (blood test) lab report.	<ul style="list-style-type: none"> <li>US/Canadian students born in 1957 or later</li> <li>If Antibody titer does not indicate immunity, injection series required.</li> <li><b>You <u>must</u> submit the antibody titer report on lab letterhead from a certified lab with definitive lab values in English.</b></li> <li>1<sup>st</sup> due at 12 months of age or older</li> <li>2<sup>nd</sup> dose administered no earlier than 28 days after 1<sup>st</sup> dose</li> </ul>
Varicella (Chicken Pox)	#1 _____ #2 _____ <b>Or</b> Attached antibody titer (blood test) lab report <b>Or</b> Definitive diagnosis of varicella by healthcare provider (history of disease reported to provider not sufficient). Provide statement from provider verifying previous infection.	<ul style="list-style-type: none"> <li><b><u>SELF/PARENTAL REPORTED HISTORY OF DISEASE NOT ACCEPTED</u></b></li> <li>All foreign born students regardless of year born.</li> <li>US/Canadian born students born during or after 1980.</li> <li>1<sup>st</sup> due at 12 months of age or older</li> <li>2<sup>nd</sup> dose administered no earlier than 28 days after 1<sup>st</sup> dose</li> <li>If Antibody titer does not indicate immunity, injection series required.</li> <li><b>You <u>must</u> submit the antibody titer report on lab letterhead from a certified lab with definitive lab values in English.</b></li> </ul>
Tetanus, Diphtheria, Pertussis (Tdap)	Tdap _____ <b>(REQUIRED)</b>	<ul style="list-style-type: none"> <li>One dose of Tdap for all students. Preferably administered after 11<sup>th</sup> birthday. Must be administered after June 10, 2005.</li> </ul>
Hepatitis B OR Hep A-Hep B (Twinrix)	#1 _____ #2 _____ #3 _____ <b>OR</b> Attached antibody titer (blood test) lab report	<ul style="list-style-type: none"> <li>All Students who will be 18 or younger on the first day of class.</li> <li>If Antibody titer does not indicate immunity, injection series required.</li> <li><b>You <u>must</u> submit the antibody titer report on lab letterhead from a certified lab with definitive lab values in English.</b></li> </ul>
Meningococcal	Menactra or Menveo _____ (MCV4) <b>Or</b> Menactra or Menveo _____ Booster (MCV4)	<ul style="list-style-type: none"> <li>All students living in in KSU Campus Housing</li> <li><b>NOTE:</b> A student may sign a statement of understanding in lieu of providing proof of immunization.</li> <li><b>NOTE:</b> It is <b>strongly</b> recommended for all students under the age of 22.</li> </ul>
Tuberculosis (TB)	All students <b>MUST</b> complete the <b>Tuberculosis Screening Questionnaire</b> found on page 2. <u>physician.</u>	<ul style="list-style-type: none"> <li>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</li> </ul>

**CERTIFICATION OF HEALTHCARE PROVIDER**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_





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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

<b>***PPD Interpretation Guidelines</b>		
<b>&gt; 5 mm is positive:</b> • Recent close contact with person with active TB • Abnormal CXR c/w past TB disease • Organ transplant or other immunosuppression HIV/AIDS	<b>&gt;10 mm is positive:</b> • 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	<b>&gt;15 mm is positive if no risk factors</b>

**SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED**

Name: \_\_\_\_\_  
 Signature: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date: \_\_\_\_\_

