IMMUNIZATION RECORD

Name: _____ Date of Birth: _____ **Page 1 of 3**

G00#:_____ Phone #: _____ Email: _____

All students MUST provide proof of immunity against measles, mumps, and rubella. Individuals born prior to January 1, 1957 are exempt from this immunization requirement, but the rest of the health requirements must be met. You may have your health care provider complete this page OR you may attach an official copy (signed by your medical provider or school nurse) you must also sign onto your Student Health Portal, at myhealth.geneseo.edu, and complete the **required** online forms under Medical Clearances.

REQUIRED IMMUNIZATIONS

MMR #1:_____(mm/dd/yy)

MMR #2:_____(mm/dd/yy)

OR

Measles Titer*: _____(mm/dd/yy)

Mumps Titer *: _____(mm/dd/yy)

Rubella Titer*: _____(mm/dd/yy)

*attach copy of titer reports to this form

MENINGOCOCCAL A IMMUNIZATION/WAIVER

♦ Must Either Report Date of Immunization or Sign Declination below.
To be COMPLETED and SIGNED by student or parent/guardian for student under the age of 18.

New York State Public Health Law requires that all college and university students enrolled must have had a meningococcal ACWY immunization within the last 5 years.

□ I received the meningococcal ACWY vaccine Date: _____
The above **cannot** be the meningococcal B vaccine.

□ I have not received a Meningococcal ACWY vaccine in the last 5 years. I have read, or have had explained to me, or understand the information regarding meningococcal meningitis disease **https://www.health.ny.gov/publications/2168/**

I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal Meningitis.

Student Signature or **Parent** Signature (if under 18)

X_____ Date:_____

RECOMMENDED IMMUNIZATIONS

Hepatitis A Vaccine #1:_____(mm/dd/yy)
Hepatitis A Vaccine #2:_____(mm/dd/yy)

Hepatitis B #1: _____(mm/dd/yy)
Hepatitis B #2: _____(mm/dd/yy)
Hepatitis B #3: _____(mm/dd/yy)

Tetanus/Diphtheria Booster (within last 10 years):
□ Td _____(mm/dd/yy)
□ Tdap _____(mm/dd/yy)

Human Papilloma Virus (HPV) Vaccine:
HPV #1:_____(mm/dd/yy)
HPV #2:_____(mm/dd/yy)
HPV #2:_____(mm/dd/yy)

MANDATORY TB SCREENING (see page 2-3).

THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER TO CERTIFY ITS ACCURACY.

Print or Stamp

Physician Name:_____

Address:_____

_____

Phone Number: _____

Fax Number: _____

Provider Signature

X_____ Date:_____

Name: _____ Date of Birth: _____ **Page 2 of 3**

G00#:_____ Phone #: _____ Email: _____

Tuberculosis (TB) is still a worldwide health problem. In consideration of public health on campus and in the community, TB Screening is **required** for ALL incoming students. The student/patient should complete screening online (MYHEALTH.geneseo.edu). The screening questions are listed below for **provider evaluation purposes**. **ANY** Yes responses to question 1-9, the patient will require proof of skin or blood test results in the past 12 months.

Tuberculosis Screening Questions:

☐ Yes	☐ No	1. Was the patient a) born outside the United States b) received a BCG vaccine or c) have a positive skin test result? **If YES, draw an Interferon Gamma Release Assay (IGRA/ T-Spot/Quantiferon) blood test and submit the lab report. Do not plant PPD/skin test.**
☐ Yes	☐ No	2. Was the patient born in one of the countries listed below that have a high incidence of active TB disease? If yes, CIRCLE the countries on the back page* and list dates.
☐ Yes	☐ No	3. Has the patient had frequent or prolonged visits to one or more of the countries listed above with a high prevalence of TB disease? If yes, CIRCLE the countries, listed on back page*.
☐ Yes	☐ No	4. Has the patient ever had the BCG vaccine?
☐ Yes	☐ No	5. Has the patient ever had close contact with persons known or suspected to have active TB disease?
☐ Yes	☐ No	6. Has the patient been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?
☐ Yes	☐ No	7. Has the patient been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?
☐ Yes	☐ No	8. Has the patient ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease (medically underserved, low-income, or abusing drugs or alcohol)?
☐ Yes	☐ No	9. Has the patient ever had a positive TB blood/skin test or been told they have/had TB?
☐ Yes	☐ No	10. If the patient had ANY positive TB test result, please submit a chest xray report. Tests/lab reports and chest X-rays should be within the past 12 months.
☐ Yes	☐ No	11. If ANY positive TB result, was the patient given counseling about taking anti-tuberculosis medication?
☐ Yes	☐ No	12. Has the patient taken anti-tuberculosis medication? If yes, please provide what medication(s); duration; if they completed the treatment.
☐ Yes	☐ No	13. Do they have signs or symptoms of active TB? (Unexplained cough greater than 2 weeks duration, fevers, chills, night sweats, weight loss or swollen glands)
☐ Yes	☐ No	14. Are they taking immunosuppressant medications such as prednisone?
☐ Yes	☐ No	15. Have they received an organ transplant?
☐ Yes	☐ No	16. Do they have HIV disease?

Name: _____ Date of Birth: _____ **Page 3 of 3**

G00#:_____ Phone #: _____ Email: _____

Tuberculin Skin Test (TST/PPD) Plant		**Tuberculin Skin Test Reading**
_____ **Date and Time Given/Planted**		_____ **Date and Time Read**
_____ **Plant Site**		_____millimeters (mm) of Induration **Results**
_____ **Drug Manufacturer**		_____Negative _____Positive **Interpretation (mark one)**
_____ **Lot# and Expiration Date**		
_____ **Nurse/Provider Signature**		_____ **Nurse/Provider Signature**

HIGH RISK Countries

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
(Based on 2017 WHO statistics)

Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia

Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar

Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands

Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe