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)	1st Dose ___/___/______ 2nd 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)	1st Dose ___/___/______ 2nd 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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Name: __________________________________

Hepatitis B (check box below) ❑ 2 dose series ❑ 3 dose series ❑ Hep A – Hep B Twinrix	Either 2 dose series or 3 dose series 1st Dose ___/____/______ 2nd Dose ___/____/______ 3rd Dose ___/____/______ **OR** attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	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.
Meningococcal MCV4/ Meningococcal ACWY/ Meningococcal Conjugate	One dose received on or after your 16th birthday. ___/____/_______	For all students 21 years old or younger and any student living in the dormitories. If your last dose was received >5 years ago, a booster dose is recommended. Please discuss with your health care provider. ❑ I attest that I am a graduate student living off campus.
Meningococcal B (check box below) ❑ 2 dose series Bexsero ❑ 3 dose series Trumenba	Either 2 dose series or 3 dose series 1st Dose ___/____/______ 2nd Dose ___/____/______ 3rd Dose ___/____/______	Required for individuals living in dorms/apartments and those younger than 23 years of age. Recommended for graduate students living off campus. ❑ I attest that I am a graduate student living off campus.
COVID-19 (check box below) ❑ Bivalent vaccine ❑ Updated Pfizer vaccine ❑ Updated Moderna Vaccine ❑ Novavax vaccine	Vaccine must have been given on or after 8/31/22 or later to be approved. 1st Dose___/____/______ 2nd Dose___/____/______	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.**

Signature of Health Care Provider and Date Required	
Name: Signature: Address: Phone Number: Date:	Office Stamp Required

Revised: 1/31/2024

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Name: ___________________________________

RECOMMENDED IMMUNIZATIONS

Recommended Vaccines	Date Administered (MM/DD/YYYY)	Recommended For
Hepatitis A (check box below) ❑ 2 dose series ❑ 3 dose series	Either 2 dose series or 3 dose series 1st Dose ___/____/______ 2nd Dose ___/____/______ 3rd 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) ❑ 2 dose series ❑ 3 dose series	Either 2 dose series or 3 dose series 1st Dose ___/____/______ 2nd Dose ___/____/______ 3rd 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:

Office Stamp Required

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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.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes_____ No _____**

History of BCG vaccination? (If yes, consider IGRA) **Yes_____ No _____**

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? **Yes ______No _____**

If no, proceed to 2 or 3.

If yes, check below:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.

2. Interferon Gamma Release Assay (IGRA) Please attach a copy of the laboratory report.

Date Obtained:______/______/______ (specify method) QFT T-Spot other___________
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Signature of Health Care Provider and Date Required
Name: Signature: Address: Phone Number: Date: Office Stamp Required

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Name: ________________________________

3. Tuberculin Skin Test (TST)

(TST result should be recorded as millimeters (mm) of induration, transverse diameter; if no induration, write "0").

Date Given:_____/_____/_____ (M D Y)   Date Read:_____/_____/_____ (M D Y)

Result: ___mm of induration   **Interpretation: positive_____negative_______

**Interpretation guidelines:

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- Foreign born or travelers to the U.S. from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

4. Chest x-ray: (Required if IGRA or TST is positive. Must attach original x-ray report)

Date of chest x-ray: _____/_____/_____ (M D Y)   Result: normal____ abnormal____

5. If you have a history of tuberculosis disease, please provide written documentation of treatment and clearance from your healthcare provider.

Signature of Health Care Provider and Date Required
Name: Signature: Address: Phone Number: Date: Office Stamp Required