

Georgetown University Student Health Center

Return to:

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 School of Continuing Studies
 Summer Programs for High School Students
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**Immunization and
 Tuberculosis Screening Certificate**

Summer 2012

Office Use Only:

IMPORTANT Please read the entire following paragraph:

All students regardless of age are screened for Tuberculosis by a risk assessment questionnaire, consistent with guidelines from the Center for Disease Control and the American College Health Association. Not all students will require placement of a tuberculin skin test. All Medical, Nursing and GEMS (health professions) students must submit immunization information and a tuberculin skin test. In addition, students under age 26 years at time of registration are required by D.C. Law 3-20 to provide documentation of vaccination or immunity (lab test, if appropriate) from Diphtheria, Tetanus, Hepatitis B, Measles, Mumps, Rubella and Varicella. Students under 18 years must be vaccinated against polio. This certificate must be returned to the Student Health Center by July 1st for the Fall term or January 1st for the Spring term. A registration block and \$100 fee may result if all requirements are not met by the first day of class. *In order to avoid delays, please see your healthcare provider as soon as possible to complete this certificate, especially if your immunization records are incomplete, and to get any required immunizations. It is your responsibility to ensure that all appropriate sections of this form are completed. Please note this form has two sides.*

PART I. To be completed by student. Please print.

Last Name First MI Age Date of Birth Country of Birth

UID# If Known Home Phone Number City State Zip Code

School Entering: ___ Undergraduate ___ Graduate ___ Medical ___ Nursing ___ Law ___ EFL ___ Special Program: _____

Date of Entry: ___ Summer 2011 ___ Fall 2011 ___ Spring 2012 ___ Summer 2012 ___ Other _____

PART II. To be completed by healthcare provider. Required if under 26 years or if a health professions student.

Polio ___/___/___ (Date series completed. Required only if under age 18 years.)
 M D YYYY

Tetanus/Diphtheria (Td) or Tdap ___/___/___ (Date of last booster. Must be within 10 years.)
 M D YYYY

MMR#1 (Measles/Mumps/Rubella) ___/___/___ (1st dose must be after 12 months of age. 2 doses required.) MMR#2 ___/___/___
 M D YYYY M D YYYY

OR

Measles #1 ___/___/___ Measles #2 ___/___/___ or attached lab report showing positive immunity _____
 M D YYYY M D YYYY

Mumps #1 ___/___/___ Mumps #2 ___/___/___ or attached lab report showing positive immunity _____
 M D YYYY M D YYYY

Rubella #1 ___/___/___ Rubella #2 ___/___/___ or attached lab report showing positive immunity _____
 M D YYYY M D YYYY

Hepatitis B #1 ___/___/___ Hepatitis B #2 ___/___/___ Hepatitis B #3 ___/___/___ (Three doses required.)
 M D YYYY M D YYYY M D YYYY

OR

attached lab report showing positive immunity _____

Varicella #1 ___/___/___ Varicella #2 ___/___/___ or Date of chicken pox disease ___/___
 M D YYYY M D YYYY M YYYY

OR

attached lab report showing positive immunity _____

Signature of Healthcare Provider Required:

Printed Name: _____ Phone: _____

Signature: _____ Date: _____

PLEASE SEE REVERSE SIDE

PRINT LAST NAME

FIRST NAME

DATE OF BIRTH

PART III. Tuberculosis questions for ALL students. Go directly to Part IV* if previous history of positive PPD.

You will need a tuberculin skin test (PPD-Mantoux test) regardless of BCG vaccination, if you meet any of the following conditions:

1. You are a health professions student (Medical or GEMS). Medical and GEMS students require a 2-step test.
2. You have signs or symptoms of active tuberculosis as determined by your healthcare provider.
3. You have a chronic medical condition such as diabetes, renal failure, HIV infection, leukemia or lymphoma or other serious condition as determined by your healthcare provider.
4. You were born in, lived in or traveled for more than 6 weeks in any country not on this list: USA, Albania, American Samoa, Andorra, Antigua, Barbuda, Australia, Austria, Barbados, Belgium, Bermuda, Virgin Islands (British and US), Canada, Cayman, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Libya, Luxembourg, Malta, Monaco, Montserrat, Netherlands and Antilles, New Zealand, Norway, Oman, Puerto Rico, St. Kitts and Nevis, St. Lucia, Samoa, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, UAE, UK.
5. You have worked or resided in settings such as nursing homes, homeless shelters, long-term hospital residential facilities, prisons, or have injected drugs in the past.
6. You have had close contact with someone with infectious tuberculosis.

If you meet any of the conditions above, you must have your healthcare provider complete Part IV. If not, sign below.

I do not meet any of the conditions 1 through 6 above and do not require further tuberculin skin testing.

Name: _____ Signature: _____ Date: _____

PART IV. PPD Testing, if required. This part to be completed and signed by healthcare provider.

A PPD-Mantoux test must be placed and interpreted by healthcare provider within the past 12 months.

PPD placed ___/___/___ PPD read ___/___/___ Result in mm induration _____ Result Positive ___ Negative ___
M D YYYY M D YYYY

2-Step Test (Medical and GEMS Students Only): 2nd PPD should be placed 1-3 weeks after the 1st PPD.

PPD placed ___/___/___ PPD read ___/___/___ Result in mm induration _____ Result Positive ___ Negative ___
M D YYYY M D YYYY

In case of a positively interpreted PPD, a chest X-ray is also required. Date of X-ray ___/___/___ Result _____
M D YYYY

OR

*Previous history of a positive tuberculin skin test: Previous PPD ___/___/___ X-ray ___/___/___
A normal chest X-ray within 12 months is required, unless M D YYYY M D YYYY
history of INH therapy is documented. Date of INH treatment _____.

Signature of Healthcare Provider Required:

Printed Name: _____ Phone: _____

Signature: _____ Date: _____

PART V. Meningitis Vaccine. Required of all Freshmen undergraduates living in residence halls.

Meningococcus vaccine: ___/___/___ You may choose to waive this requirement. However, if you choose to waive you
M D YYYY must read the Meningitis Fact Sheet, then sign and submit the Meningitis
Vaccination Waiver. Both are found at shc.georgetown.edu.

PART VI. Consent for treatment of student under 18 years of age. To be completed by parent or guardian.

Parental permission or consent of legal guardian is needed to provide medical or surgical care to minors. The following statement should be signed by parents or guardians of students under 18 years of age to avoid delays in treatment in the event of an illness or accident:

I hereby authorize the staff of Georgetown University Student Health Center to interview, assess, test and if necessary treat my son or daughter as deemed advisable. Signature: _____ Date: _____

Parent or Guardian

PART VII. Request for Exemption.

Religious exemption is allowed if the responsible person objects in good faith, in writing, that immunizations violate his or her religious beliefs. This exemption does not apply to tuberculosis screening. Medical exemption is allowed if a physician or health authority deems an immunization medically inadvisable. Explicit written documentation supporting an exemption request must be submitted with this certificate.

Religious Exemption _____ Medical Exemption _____