Student Health Services

UNIVERSITY LIFE LIVING • LEARNING • LEADING

ARLINGTON CAMPUS
Founders Hall, Room B102
3351 Fairfax Dr.
Arlington, VA 22201
Phone (703) 993-4863

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SUB I, Room 2349
4400 University Drive, 2D3
Fairfax, VA 22030
Phone: 703-993-2135
703-993-2836 for information only
Fax: 703-993-4053
Submit forms to Fairfax

Immunization Record

Website: http://shs.gmu.edu/immunizations/
Email: immunize@gmu.edu - No records accepted through email.

Students born after 12/31/1956 must provide proof of compliance with immunization requirements of the Commonwealth of Virginia and George Mason University. Regardless of age ALL students are required to complete the tuberculosis screening form (pg 2 of this form). Students who fail to comply with these requirements will not be able to enroll for courses the following semester. If you are unable to provide appropriate documentation, vaccines or titers are available at SHS for a fee.

Completed Immunization Records are due to Student Health Services by March 1st for incoming Spring Students and October 1st for incoming Fall Students. Late and incomplete records will be assessed a $25 LATE FEE and a hold will be placed on your Patriot Web Account. This form must accompany any records turned in.

PART 1. Personal Information to be completed by the STUDENT- PLEASE PRINT.

Last Name:	First Name:	Student ID #
US Address:		
City:	State:	Zip:
Date Of Birth:	Home Phone:	Cell Phone:

PART 2. MINOR CONSENT—REQUIRED ONLY IF STUDENT IS UNDER 18 YEARS OF AGE AT THE TIME OF ENROLLMENT

Parental permission or the consent of a legal guardian must be obtained to provide medical or surgical care to minors. To avoid delays in treatment in the event of illness or accident, please obtain the signature of a parent/legal guardian if you are under 18 years of age at the time of enrollment.
I hereby authorize the staff of George Mason University Student Health Services to assess, test, administer vaccines, and if necessary, treat my minor or dependent as deemed advisable.

______________________________ ______________________________
Signature of Parent or Guardian Date

______________________________ ______________________________
Printed Name of Parent or Guardian Relationship

PART 3. EMERGENCY CONTACT INFORMATION

In the event of an emergency I give Student Health Services permission to contact:
Name: ____________________ Phone: (H) ______________ (C)______________

Initial for permission to contact: __________

PART 4. EXEMPTIONS: DOES NOT APPLY TO TUBERCULOSIS TESTING

Medical: Letter from Health Care Provider must accompany this form. Religious Exemption: Original Form CRE-1

PART 5. DISCLAIMER —To be signed and dated by Student

Student Health Services reserves the right to request supporting documentation of your immunization records, and request titers and/or vaccinations at your expense.

Student Signature: ______________________________ Date:____________________

Student Name: ____ G#: ____________________

PART 6. TUBERCULOSIS SCREENING— to be completed by the STUDENT and/or reviewed by a healthcare provider

Tuberculosis (TB) screening is required of all students. Please answer the following questions:

1. Were you born in countries where tuberculosis is endemic, **AND** arrived in the US within the last 5 years? Yes No

   Date Arrived in or intent to arrive in US: ________

2. Have you travelled to in countries where tuberculosis is endemic, **for three consecutive months or more within the last 5 years**?

   Dates Traveled last 5 years: ____________ Length of Stay: __________ Yes No

   Country Traveled: _________________

3. Are you a Health Care Worker, Nursing Student or is a TB test required by your employer or volunteer position? Yes No

4. Have you had close contact with anyone who is/was sick with Tuberculosis? Yes No

5. Do you have any medical conditions such as diabetes, chronic renal failure, leukemia, or lymphoma, HIV infection or any other immunosuppressive disorder? Yes No

6. Do you have any symptoms of active Tuberculosis, such as: cough >3 weeks, night sweats, fever, unexplained weight loss and/or fatigue? Yes No

7. Have you resided in, volunteered or worked in a high-risk congregate setting such as prisons, nursing homes, hospitals or homeless shelters. Yes No

If the answer to all of the above questions are **NO, no TB testing or Chest X-Ray** is required, please go to Part 8. If the answer is **YES** to any of the above questions, George Mason University requires your Health Care Provider fill out Part 7Tuberculosis Test.

____
Initialed by Student

List of Countries for Questions 1 and 2:

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbajjan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Batswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Rep., Chad, China, Colombia, Comoros, Congo, Cote d' Ivoire, Croatia, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guan, Guatemala, Guinea, Guinea - Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Micronesia (Federated State of), Monglia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, St. Vincent & The Grenadines, Sao Tome & Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Tongo, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe

Student Name: ____ G#: ________________________

PART 7. TUBERCULOSIS TEST — TO BE COMPLETED BY A HEALTH CARE PROVIDER

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN TESTING AND/OR CHEST RADIOGRAPHY (X-Ray) OR LTBI TREATMENT IF INDICATED

Has the patient ever had a positive TST test? Yes No
If No, go to Section A; **If yes**: Date:__________ Result: _______ go to Section B below.

Students who have had a BCG are still required to have a TB skin test.

If a test is required it must be performed within the last 6 months (from the date of admission to Mason).

Section A.) Tuberculin Skin Test

Date Placed: ___/___/___ Date Read: ___/___/___ Result: _______mm

Please Record actual mm of induration, transverse diameter; if no induration, write "0".

-or-

B Immunoassay blood test: Date performed: __/__/__ Date read: __/__/__ Result: Normal Abnormal

Section B.) Chest X-Ray (required if Tuberculin Skin test is positive; or if history of positive TST with no chest x-ray report. New Chest x-ray is not required if patient is currently undergoing or has completed LTBI treatment

A copy of the chest x-ray report and/or proof of treatment must accompany this form.

Date of Chest X-Ray: ___/___/___ Result: Normal Abnormal

Previous Treatment for LTBI or TB

A copy of the chest x-ray report and/or proof of treatment must accompany this form.

Date and result of last chest x-ray: ___/___/___ Result: Normal Abnormal

Dates (i.e. length) and details (i.e. drugs, dose) of LTBI treatment regimen:

From ___/___/___ To ___/___/___ Details:____

Health Care Provider Initials: __________________

PART 8. REQUIRED IMMUNIZATIONS — to be completed by a healthcare provider— must also complete and sign PART 10.

Tetanus—Diphtheria: Booster within past 10 years	_____/_____/_____ Tdap or _____/_____/_____ Td
Measles, Mumps, Rubella (MMR): 2 doses required at least 1 month apart. First dose must be given at, or after, one year of age.	**(1)** ____/____/____ **(2)** ____/____/____ **OR** copy of titer indicating positive immunity must accompany this form.
Or ALL 3 OF THESE CRITERIA ARE MET:	
Measles (Rubeola)	**(1)** ____/____/____ **(2)** ____/____/____ **OR** copy of titer indicating positive immunity must accompany this form.
Mumps	**(1)** ____/____/____ **(2)** ____/____/____ **OR** copy of titer indicating positive immunity must accompany this form.
Rubella (German Measles)	**(1)** ____/____/____ **(2)** ____/____/____ **OR** copy of titer indicating positive immunity must accompany this form.
Hepatitis B (HBV): Must receive all three doses to be considered fully immunized	(1) ___/___/___ **(2)** ___/___/___ **(3)** ___/___/___ ☐ Hepatitis B ☐ Twinrix ☐ Hepatitis B ☐ Twinrix ☐ Hepatitis B ☐ Twinrix **OR** copy of titer indicating positive immunity must accompany this form, **OR** signed waiver (only if NOT a nursing student) on pg. 4 of form
Meningococcal (Meningitis): One dose after the age of 16 is required Menactra or Menomune or Menveo	___/___/___ or ☐ signed waiver on pg. 4 or ☐ graduate student or ☐ not under 22 yrs old

Student Name: ______________________________ G#: ____________________

PART 9. RECOMMENDED VACCINATIONS — to be completed by a healthcare provider, must also complete and sign PART 10.

Varicella (chicken pox):	(1)___/___/___ (2) ___/___/___
Human Papillomavirus (HPV): Gardasil or Cervarix	(1)___/___/___ (2) ___/___/___ (3) ___/___/___
Hepatitis A (If Twinrix, see Part 8, Hepatitis B):	(1) ___/___/___ (2) ___/___/___
Other:	___/___/___ ___/___/___ ___/___/___

PART 10. HEALTH CARE PROVIDER INFORMATION AND SIGNATURE:

❑ Transcribed records ❑ Gave Vaccine(s) to student

Printed Name and Title:	
Name of Practice or Clinic:	
Address:	
Phone Number:	

Healthcare Provider Signature: ______________________________ Date ____________

Waiver of Immunization Against Hepatitis B Disease (medical and nursing students are required to receive this vaccine):

Hepatitis B is a serious liver disease caused by the hepatitis B virus (HBV). HBV infection can affect people of all ages and lead to liver disease. The virus is found in the blood and body fluids of infected people it is most often spread among adults through sexual contact or by sharing needles and other drug paraphernalia with an infected person. HBV can also be spread in households of HBV-infected persons or by passage of the virus from an HBV-infected mother to her infant during birth. Hepatitis B can be a silent disease, often infecting many people without making them feel sick. Unfortunately, 30 percent of those infected with HBV are not aware that they are carriers and can infect others. Hepatitis B symptoms might include loss of appetite, fatigue, stomachache, nausea and vomiting, yellowing of the whites of the eyes (jaundice), and/or joint pain. Vaccination can help prevent people from contracting hepatitis B. The HBV vaccine is 96 percent effective following a series of three shots over a six-month period. The most common side effect of the vaccine is soreness at the injection site. Vaccine recipients cannot get the disease from the vaccine.

*I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at anytime. I have received and reviewed the information regarding hepatitis B and the availability and effectiveness of the hepatitis B vaccine. I have chosen **not** to be vaccinated (or I am unable to provide current vaccination records) against hepatitis B.*

______________________________ ______________________________

Signature of Student **Date** **If student is a minor, signature of parent/guardian** **Date**

Waiver of Immunization Against Meningococcal Disease (medical and nursing students are required to receive this vaccine):

Meningitis is an inflammation of the linings of the brain and spinal cord. It is caused by bacteria called *Neisseria meningitidis.* The bacteria are transmitted through air-borne droplets of respiratory secretions and by direct contact with infected persons. Although bacterial meningitis occurs rarely and sporadically throughout the year, increased outbreaks occur among college students, especially those who live in residence halls. Early symptoms of meningococcal disease include fever, severe headache, stiff neck, rashes, and exhaustion. If not treated early, meningitis can lead to severe and permanent disabilities or even death. A vaccine is available that protects against four strains of the bacteria that cause meningitis in the United States: types A, C, Y, and W-135. These types account for nearly two-thirds of meningitis cases among college students. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. The vaccine is 85 to 100 percent effective.

*I have received and reviewed the information regarding meningococcal disease and the availability and effectiveness of the meningococcal vaccine. If in the future I want to be vaccinated with meningococcal vaccine, I can receive the vaccination at anytime. I have chosen **not** to be vaccinated against meningococcal disease.*

______________________________ ______________________________

Signature of Student **Date** **If student is a minor, signature of parent/guardian** **Date**