INSTRUCTIONS FOR COMPLETING THE REQUIRED IMMUNIZATION FORMS

Please attach Immunization and TB forms to the application as they are part of the application process and are due at the same time as the application. *Current UGA students do not need to complete immunization form.*

Address: University of Georgia
Studies Abroad - Cortona
270 River Road
Athens, GA 30602-7676

FAX: 706-542-4270

Certificate of Immunization – Required (page 1)

A. It is the policy of the University Health Center to comply with the mandatory immunization program established by the Board of Regents of the University System of Georgia. These requirements include documented proof of immunity to measles, mumps, and rubella, varicella (chicken pox), tetanus, and hepatitis B, prior to registration at any college or university within the University System. No temporary clearances are given to allow registration without meeting these requirements. Please note that dates of immunizations and titers with results are required. The physician or other healthcare provider must sign the form. Any request for consideration of exemption must have signed documentation attached.

Tuberculosis (TB) Screening Questionnaire – Required (page 2)

A. Complete the form, answering the four questions, signing and dating. If you answer "NO" to all 4 questions, you do NOT need to turn in the "Tuberculosis (TB) Risk Assessment (page 3)

B. If you answer "yes" to ANY of the 4 questions, then you need to take the "Tuberculosis (TB) Risk Assessment - Required if risk noted on TB Screening Questionnaire" to your healthcare provider to fill out, sign and date. It must be turned in with the other immunization forms.

Tuberculosis (TB) Risk Assessment – Required if risk noted on TB Screening Questionnaire (page 3)

A. Complete Section A. Patient Section.

B. A United States or Canada physician must complete Section B.
- Persons with any identified risk factors must receive either one Mantoux tuberculin skin test (TST) or have a blood test drawn for Interferon Gamma Release Assay (IGRA).
- The form and results must be evaluated and signed by a United States or Canada physician or healthcare provider.
- This TB Risk Assessment form must be completed prior to the first day of classes, and no longer than 30 days after the first day of classes. Information provided must be dated no more than one year prior to the first day of classes.
- Eligible students may choose to complete the TB Risk Assessment on site at the University Health Center (UHC) once on campus in Athens. Fees are charged for the TST, IGRA, chest x-ray and sputum test at UHC.

****TST 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
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF- antagonist
- Persons with HIV/AIDS

>10 mm is positive:
- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronicmal absorption syndromes

>15 mm is positive:
- Persons with no known risk factors for TB disease

University Health Center
The University of Georgia
Athens, GA 30602-1755
706-542-8617 Health Information
706-542-4959 Fax

Name _____
UGA ID#_____
Date of Birth _____
Phone _____

CERTIFICATE OF IMMUNIZATION (REQUIRED)

REQUIRED IMMUNIZATIONS	REQUIREMENT	REQUIRED FOR:
MMR (Measles, Mumps, Rubella) combined shot	•2 Doses #1 ___/___/___ #2 ___/___/___	• Students born in 1957 or later
- - - - - - - - - OR - - - - - - - - - - - -	**- - - - - - - - - - - OR - - - - - - - - - - - - - -**	- -
• **Measles (Rubeola)**	• 2 Doses #1 ___/___/___ #2 ___/___/___	• Students born in 1957 or later
and	• **or** Titer ___/___/___	
	and	
• **Mumps**	• 2 Doses #1 ___/___/___ #2 ___/___/___	• Students born in 1957 or later
and	• **or** Titer ___/___/___	
	and	
• **Rubella (German Measles)**	•1 Dose #1 ___/___/___ • **or** Titer ___/___/___	• All students • Attach titer results if done
Varicella (Chicken Pox)	• 2 Doses #1 ___/___/___ #2 ___/___/___ • **or** History of chicken pox or shingles ___/___/___ • **or** Titer ___/___/___	• All U.S. born students born in 1980 or later and all foreign born students regardless of year born • Attach titer results if done
Tetanus and Diphtheria (Td or Tdap)	• Td ___/___/___ • **or** Tdap ___/___/___	• All students must have one dose within 10 years
Hepatitis B	• 3 Dose series #1 ___/___/___ #2 ___/___/___ #3 ___/___/___	• All students 18 years of age or less at matriculation
Tuberculosis screening	• Must complete TB screening questionnaire, page 2 of this form	• All students. All students, with risk noted, must complete the TB Risk Assessment, page 3 of this form.

OPTIONAL IMMUNIZATIONS

Hepatitis A	2 doses	#1 ___/___/___	#2 ___/___/___	
Gardasil	3 doses	#1 ___/___/___	#2 ___/___/___	#3 ___/___/___
Meningitis	1 dose	___/___/___		
Other vaccines: _____		___/___/___	_____	___/___/___

REQUEST FOR EXEMPTION

☐ Temporary medical exemption until ___/___/___ Attach verification by doctor	☐ Permanent medical exemption Attach verification by doctor	☐ Religious exemption Attach verification by religious leader

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

Name _____ Address _____

Signature _____ _____

Date _____ Phone _____ 12/08

University Health Center
The University of Georgia
Athens, GA 30602-1755
706-542-8617 – Health Information
706-542-4959 – Fax for Health Forms

Name _____
UGA ID # _____
Date of Birth _____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (REQUIRED)

Complete this form and return to the University Health Center prior to the first day of class at UGA.

- Have you ever had a positive TB skin test? ☐ Yes ☐ No
- Have you ever had close contact with anyone who was sick with TB? ☐ Yes ☐ No
- Were you born in one of the countries listed below* and arrived in the U.S. within the past 5 years? If yes, please CIRCLE the country. ☐ Yes ☐ No
- Have you ever been vaccinated with BCG (bacille Calmette-Guérin) vaccine? ☐ Yes ☐ No

If the answer is YES to any of the above screening questions, you must complete page 3.
The University of Georgia requires that students complete a tuberculosis risk assessment by a physician or healthcare facility in the United States or Canada. This TB Risk Assessment (pages 3) must be completed no later than 30 days following the first day of the initial semester at UGA. TB Risk Assessment may be completed at the University Health Center, UGA, Athens, GA, following the first day of classes during the initial enrolled semester.

If the answer is NO to all of the above questions, no further assessment is required.
Mail this signed form to the University Health Center, The University of Georgia, Athens, GA, 30602 or fax to 706-542-4959.

Signature of Student _____ Date _____
OR Signature of parent if student is <18 years old

* List of countries:

Afghanistan	DR - Congo	Kazakhstan	Nepal	South Africa
Algeria	Cote d'Ivoire	Kenya	New Caledonia	Spain
Angola	Croatia	Kiribati	Nicaragua	Sri Lanka
Anguilla	Djibouti	DPR - Korea	Niger	Sudan
Argentina	Dominican Republic	Republic of Korea	Nigeria	Suriname
Armenia	Ecuador	Kuwait	Niue	Swaziland
Azerbaijan	Egypt	Kyrgyzstan	N. Mariana Islands	Syrian Arab Republic
Bahamas	El Salvador	Lao PDR	Pakistan	Tajikistan
Bahrain	Equatorial Guinea	Latvia	Palau	Tanzania UR
Bangladesh	Eritrea	Lesotho	Panama	Thailand
Belarus	Estonia	Liberia	Papua New Guinea	Timor-Leste
Belize	Ethiopia	Lithuania	Paraguay	Togo
Benin	Fiji	TFYR of Macedonia	Peru	Tokelau
Bhutan	French Polynesia	Madagascar	Philippines	Tonga
Bolivia	Gabon	Malawi	Poland	Tunisia
Bosnia & Herzegovina	Gambia	Malaysia	Portugal	Turkey
Botswana	Georgia	Maldives	Qatar	Turkmenistan
Brazil	Ghana	Mali	Romania	Tuvalu
Brunei Darussalam	Guam	Mauritania	Russian Federation	Uganda
Bulgaria	Guatemala	Mauritius	Rwanda	Ukraine
Burkina Faso	Guinea	Mexico	St. Vincent & The Grenadines	Uruguay
Burundi	Guinea-Bissau	Micronesia	Sao Tome & Principe	Uzbekistan
Cambodia	Guyana	Moldova-Rep	Saudi Arabia	Vanuatu
Cameroon	Haiti	Mongolia	Senegal	Venezuela
Cape Verde	Honduras	Montenegro	Seychelles	Viet Nam
Central African Republic	India	Morocco	Sierra Leone	Wallis & Futuna Islands
Chad	Indonesia	Mozambique	Singapore	W. Bank & Gaza Strip
China	IR - Iran	Myanmar	Solomon Islands	Yemen
Colombia	Iraq	Namibia	Somalia	Zambia
Comoros	Japan	Nauru		Zimbabwe
Congo				

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population.

University Health Center review _____ Date _____

University Health Center
The University of Georgia
Athens, GA 30602-1755
706-542-8617 Health Information
706-542-4959 Fax for health forms

Name _____
UGA ID# _____
Date of Birth _____

TUBERCULOSIS (TB) RISK ASSESSMENT (Required if risk noted on TB Screening Questionnaire)

A. Patient Section

Recent close contact with someone with infectious TB disease	☐ Yes ☐ No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America) * *This significance of the travel exposure should be discussed with a health care provider and evaluated.*	☐ Yes ☐ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No
Organ transplant recipient	☐ Yes ☐ No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-α anatagonist)	☐ Yes ☐ No
History of illicit drug use	☐ Yes ☐ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)	☐ Yes ☐ No
Medical condition associated with increased risk of progressing to TB disease if infected [e.g, diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]	☐ Yes ☐ No

B. Healthcare provider section: Discuss the significance of exposure and evaluate the patient.

1. **Does the student have signs or symptoms of active tuberculosis disease?**

   ☐ Yes Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing (TST), chest x-ray, and sputum evaluation as indicated.

   ☐ No Proceed to #2 or #3**.** Completion of either #2 or #3 is required for **all** students with any risk factor noted above.

2. **Tuberculin Skin Test (TST)** TST result must be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors. **See guidelines** listed on instructions page.**

   Date Given: ____/____/_____ (mm dd yyyy) Date Read: ____/____/_____ (mm dd yyyy)

   Result: _____ mm induration **Interpretation: positive_☐_ negative_☐_

3. **Interferon Gamma Release Assay (IGRA)**: Check the specific method: ☐ QFT-G ☐ QFT-GIT ☐ other _____

   Date Obtained: ____/___/_____ (mm dd yyyy) Result: ☐ Negative ☐ Positive ☐ Intermediate

4. **Chest x-ray**: Required if TST or IGRA is positive, or symptoms of active disease present. Attach a copy of the chest x-ray report to this document.

   Date of chest x-ray: ____/____/_____ (mm dd yyyy) Result: ☐ normal ☐ abnormal

5. **Sputum evaluation:** Required if TST or IGRA is positive, or symptoms of active disease present. Attach a copy of the sputum report to this document.

   Date performed: ____/____/_____ (mm dd yyyy) Result: ☐ normal ☐ abnormal

Required signature of United States or Canada Healthcare physician or healthcare facility:

Name _____ Phone _____

Address _____ City, State, Zip Code _____

Signature_____ Date_____ *10/2008*