Morehouse School of Medicine Immunization Form

Effective Nov 2012, all incoming students/residents must meet the CDC and American College Health Association immunization guidelines ***prior to registration for classes****. Please be sure to* ***have the form verified by the signature of your licensed healthcare provider or enclose a copy of your official, signed immunization records****. If for any reason you or your providers feel that you cannot comply with any of the requirements, please attach a letter of explanation signed by both you and your healthcare provider. For additional information or questions, please contact Infection Control at 404.756.5036 or the Student Employee Health Services at 404.756.1241****. NOTE: It is acceptable to attach your health care provider's documents or standard immunization record to this form that validate required information.***

Name _____ _____
First Name Middle Name

_____ _____
Last Name Social Security Number (Optional)

Address _____
Street City State Zip

Date of Entry ____/_____ Date of Birth ____/____/_____ MSM ID# _____
M Y M D Y (MSM office use only)

Status: Student Program _____ _____Medical Student _____ Yr _____ Resident_____ Dept _____

PART II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (*All information must be in English)*

A. MMR (MEASLES, MUMPS, RUBELLA) (Two doses required at least 28 days apart for students born after 1956.)

1. Dose #1 given at age 12 months or later. ..... ____/____/_____
M D Y
2. Dose #2 given at least 28 days after first dose. ..... ____/____/_____
M D Y

OR

Measles antibody ____/____/_____ Result: Immune _____ Non-Immune _____
M D Y

Mumps antibody ____/____/_____ Result: Immune _____ Non-Immune _____
M D Y

Rubella antibody ____/____/_____ Result: Immune _____ Non-Immune _____
M D Y

B. VARICELLA*(Two doses required)*

1. a. Dose #1 ..... ____/____/_____
M D Y

b. Dose #2 given at least 12 weeks after first dose ages 1-12 years. ..... ____/____/_____
and at least 4 weeks after first dose if age 13 years or older. M D Y

OR

2. Varicella antibody ____/____/_____ Result: Immune _____ Non-Immune _____
M D Y

C. TETANUS, DIPHTHERIA, PERTUSSIS (*Tdap booster every ten years recommended for ages 11-64 unless contraindicated*.)

1. Primary series completed? Yes ___ No ___

   Date of last dose in series: ____/____/_____
   M D Y

2. Date of most recent booster dose: ____/____/_____
   M D Y

   Type of booster: Td _____ Tdap _____

D. HEPATITIS B *(Three doses required)*

1. Immunization (Hepatitis B)

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
M D Y M D Y M D Y

OR

2. Hepatitis B surface antibody Date ____/____/_____ Result: Immune _____ Non-Immune _____
M D Y

E. Tuberculin Skin Test (PPD) *(Required annually of all medical students and any student who will have contact with patients during the academic year.)*

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

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

Chest X-ray (required if PPD skin test is positive. Please attach a copy of the report) Normal_____ Abnormal _____
Date Read ____/_____/_____

Treatment: Have you been treated with INH drug therapy? Yes ___ No ___ From ____/ ____/ _____ TO _____/_____/_____

***If yes, complete TB screening Questionnaire**

Have you received the BCG Vaccine? Yes _____ No _____ Date ____/ _____/ _____

TB Screening Questionnaire

In the past 6 months have you experienced any of the following for greater than three weeks?

Excessive sweating at night	Yes ☐	No ☐
Excessive weight loss	Yes ☐	No ☐
Persistent coughing	Yes ☐	No ☐
Excessive Fatigue	Yes ☐	No ☐
Coughing up blood	Yes ☐	No ☐
Hoarseness	Yes ☐	No ☐
Persistent Fever	Yes ☐	No ☐

Additional Vaccines **You may have already received, but are NOT required for entrance to the program**				
		Month	Date	Year
Hepatitis A Vaccine #1				
Hepatitis A Vaccine #2				
Polio last booster				
Yellow Fever				
Typhoid	☐ oral ☐ injection			

Verification of the above Immunization Record by healthcare Provider:

_____ _____ Date: _____

Print Name of Healthcare Provider Signature of Healthcare Provider

PLEASE return this form via mail to:

Student Employee Health Services and Infection Control
1513 East Cleveland Ave Bldg 500
East Point, Georgia 30344