CLARK ATLANTA UNIVERSITY

Student Health Services
Immunization/ Tuberculosis Screening Record

PART I

Name _____ _____
Last, First, M.I Telephone Number

Address _____
Street City State Zip

Date of Enrollment ____/_____ Date of Birth____/____/_____ School ID# _____
M Y M D Y

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate _____

PART II: TO BE COMPLETED, STAMPED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA) (Required)

Two doses required at least 28 days apart for students born after 1956.

Dose 1 given at age 12 months or later. ..... #1____/____/_____
M D Y

Dose 2 given at least 28 days after first dose. ..... #2____/____/_____
M D Y

OR Positive antibody titer (blood test) lab report required.

B. MENINGOCOCCAL QUADRIVALENT (Required)

MenACWY or Conjugate 2 doses; 2nd dose to be given after age 16.

Dose #1_____/_____/_____ Dose #2____/_____/_____
M D Y M D Y

MENINGOCOCCAL B (Bexero, Trumenba)(**Recommended**)

Date ____/____/_____
M D Y

C. TETANUS, DIPHTHERIA, PERTUSSIS (Required)

Must be within the last ten years and remain current throughout matriculation.

Date of most recent booster dose: ____/____/_____ Type of booster: Td _____ Tdap _____
M D Y *Tdap booster recommended for ages 11-64 unless contraindicated*

D. HEPATITIS B Series (Required)

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

OR Hepatitis B titers: Date performed: ____/____/_____ Results: Lab report required
M D Y

E. VARICELLA Vaccine (Required) Historical report not acceptable without titer

1st dose given at age 12 months or later.

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

OR Positive titers: Date drawn: ____/____/_____ Results: Lab report required
M D Y

F. COVID-19 Vaccination Series (Required)

COVID-19: Choose vaccine name- Moderna_____ Pfizer _____ Janssen/J&J _____or other WHO approved vaccine____

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

****Covid-19 EXEMPTION**: In order to waive the COVID-19 vaccine requirement you must download the waiver form linked on the login page of Point and Click Patient Portal and attach to this document.**

Name:_____ School ID# _____

G. TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by **health care provider)**

Tuberculin Skin Test (TST) (Required within past 12 months)

(The TST interpretation should be based on mm of induration as well as risk factors)

Date Given: ____/____/____Time:

Date Read: ____/____/____Time:

M D Y

Result:_____mm of induration (Must be numerical) If no induration, write "0". An induration 10mm or above requires a chest x-ray

****Interpretation: Negative____ Positive _____**

Interferon Gamma Release Assay (IGRA): (**specify method and attach report**) QFT-GIT _____ T-Spot _____ other_____

Result: negative____ positive____ indeterminate____ borderline____(T-Spot only)

Chest x-ray (Attach Report): (Required if TST induration is 10mm or above or IGRA is positive)

Date of chest x-ray:____/____/____ Result: normal____abnormal_____

M D Y

H. Medical Exemption: (Attach Verification by Healthcare Provider)

❑ Exemption on grounds of permanent medical contraindication

❑ Exemption on grounds of temporary medical contraindication- Expected end date____/____/____

M D Y

I. Religious Exemption:

❑ I affirm that immunizations as required by Clark Atlanta University are on conflict with my religious beliefs. I understand that I am subject to exclusion in the event of a disease for which immunization is required. (**Attach Notarized Affidavit)**

Notice: Permission is hereby granted for Clark Atlanta University Health Services staff and/or their consultants to carry out indication medical and surgical treatment. Major surgery or illness cases are transferred to other Atlanta area hospitals. Permission will be sought by the hospital and attending private physician prior to surgery and/or treatment.

_____ _____

Signature of Student or Parent (If student is under the age of 18) **Date**

HEALTH CARE PROVIDER

Name_____Signature_____Date_____

Address_____ Phone (_____)_____

Input immunization dates and upload completed form to

Point and Click Patient Portal

Contact our office at (404)880-8322 if you have any issues

Rev 04/2023