University of Redlands

2018 - 2019
Immunization Verification
All students must complete this form and return it to the
Student Health Center
health_center@redlands.edu ● 1200 E. Colton Ave. Redlands, CA. 92373-0999
Telephone (909) 748-8021 ● Fax: (909) 335-5117

________________________________________________________________________

Student Information:

Name: ___________________________ Student ID: ___________________________

Date of Birth: _____________________

There are two ways to provide us with your immunization information.

1) Students can have their healthcare provider fill out and sign the form below. A healthcare provider’s signature or office stamp must be included on the form.

OR

2) Students may fill in the form below AND attach a copy of their Immunization Record, or other documentation (lab tests) from their healthcare provider as proof that all the requirements have been met. Please note that if the student has filled in the form, but the immunization record or lab results are not attached, the form is considered incomplete.

Additional information about the vaccine requirements is provided on page 2 of this form.

1. Measles, Mumps, Rubella (MMR): REQUIRED

   #1 __________  #2 __________

   OR Immunity verified by immune titer (please attach report)

   * No titer needed if proof of two doses of MMR provided

2. Varicella (Chicken Pox): REQUIRED

   #1 __________  #2 __________

   OR Immunity verified by immune titer (please attach report)

   * No titer needed if proof of two doses of Varicella provided

3. Hepatitis B: REQUIRED

   #1 __________  #2 __________  #3 __________

   OR Immunity verified by immune titer (please attach report)

   * No titer needed if proof of three doses of HBV provided

4. Tetanus, Diptheria, Pertussis (Td, Tdap): REQUIRED

   Booster within last 10 years ____________  [ ] TdaP  [ ] Td

5. Meningococcal Vaccine: REQUIRED **Note: If the first dose was given before age 16, a second dose (booster) must be given.

   #1 __________  #2 (booster) __________

6. TB Screening Questionnaire: REQUIRED – Please complete the attached questionnaire on page 3

Health Care Provider Signature or Office Stamp

Health Care Provider’s Name (please print) ___________________________

Address: _____________________________________________________________

Street __________ City __________ State __________ Zip code __________

Phone (______)___________  Fax (______)___________

Signature (or stamp) __________________________________________ Date __________

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Phone (______)___________  Fax (______)___________

Signature (or stamp) __________________________________________ Date __________
Additional information about required vaccinations

The University of Redlands' immunization requirements are based on the recommendations from the Centers for Disease Control and Prevention (CDC) as well as the California Department of Public Health. Pursuant to SB 277, exemptions from required vaccinations are no longer available based on "personal beliefs" (personal beliefs include, but are not limited to religious beliefs); the only recognized exemptions are for medical reasons certified by a licensed physician.

Measles, Mumps and Rubella (MMR)

All students are required to show Measles, Mumps, and Rubella (MMR) immunity prior to arriving on campus. Immunity can be shown by proof of two doses of vaccine. If immunization records are not available, a medical provider can order a blood test (titer) to determine immunity. * Titer is not required if two doses of MMR are documented.

Varicella (Chicken Pox)

Students must show proof of immunity to Varicella prior to arriving on campus. Immunity can only be shown by proof of two doses of vaccine, or through a blood test (titer). * Titer is not required if two doses of Varicella are documented.

Tetanus, Diptheria and Pertussis (Tdap) or Tetanus-Diptheria (Td)

A booster dose should have been given within the last 10 years. Students should have received a Tdap or Td booster at age 11 or later. It is strongly recommended that Tdap should replace a single dose of Td for adults aged 19 and older who have not received a dose of Tdap previously.

Meningococcal

2 doses: If the first dose was given before age 16, a second dose (booster) must be given. This is recommended by both the Centers for Disease Control, as well as the California Department of Public Health.

TB Screening Questionnaire

Please read the instructions and complete the TB Screening Questionnaire on page 3. Start by completing Part I. If all the answers to Part I are “no,” no further testing or action is required. Return page 3 to the Student Health Center along with page 1 of the Immunization form. If the student answers "yes" to any questions on Part I, proceed to Part II (pages 4 & 5).
Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:
If the answer is YES to any of the questions below, proceed to Part II of this form, found on the next page.
If the answer to all of the questions below is NO, no further testing or action is required.
Return this form to the Student Health Center along with page 1 of the Immunization Verification form.

Have you ever had close contact with persons known or suspected to have active TB disease?  
☐ Yes  ☐ No

Were you born in one of the countries listed below that have a high incidence of active TB disease?  
☐ Yes  ☐ No

(If yes, please CIRCLE the countries, below)

Afghanistan  Côte d’Ivoire  Kenya  Nicaragua  South Africa
Algeria  Democratic People’s Republic of Korea  Kiribati  Niger  South Sudan
Angola  Democratic Republic of the Congo  Kyrgyzstan  Nigeria  Sri Lanka
Argentina  Congo  Lao People’s Democratic Republic  Niue  Sudan
Armenia  Djibouti  Latvia  Pakistan  Suriname
Azerbaijan  Dominican Republic  Lithuania  Palau  Swaziland
Bahrain  Ecuador  Madagascar  Papua New Guinea  Tajikistan
Bangladesh  El Salvador  Malawi  Paraguay  Thailand
Belarus  Equatorial Guinea  Malaysia  Peru  Timor-Leste
Belize  Eritrea  Maldives  Philippines  Togo
Benin  Estonia  Mali  Poland  Trinidad and Tobago
Bhutan  Ethiopia  Marshall Islands  Portugal  Tunisia
Bolivia (Plurinational State of)  Fiji  Mauritania  Russian Federation  Ukraine
Bosnia and Herzegovina  Gabon  Mauritius  Rwanda  United Republic of Tanzania
Botswana  Georgia  Micronesia (Federated States of)  Saint Vincent and the Grenadines  Vanuatu
Brazil  Gambia  Mali  Sao Tome and Principe  Venezuela (Bolivarian Republic of)
Brunei Darussalam  Georgia  Marshall Islands  Senegal  Yemen
Bulgaria  Ghana  Mauritius  Serbia  Zambia
Burkina Faso  Guatemala  Micronesia  Seychelles  Zimbabwe
Burundi  Guinea  Mexico  Senegal  South Africa
Cabo Verde  Guinea-Bissau  Micronesia (Federated States of)  Sao Tome and Principe  South Africa
Cambodia  Guyana  Mongolia  Saudi Arabia  South Africa
Cameroon  Haiti  Morocco  Senegal  South Africa
Central African Republic  Honduras  Mozambique  Singapore  South Africa
Chad  India  Myanmar  South Africa  South Africa
China  Indonesia  Namibia  South Africa  South Africa
Colombia  Iran (Islamic Republic of)  Nauru  South Africa  South Africa
Comoros  Iraq  Nepal  South Africa  South Africa
Congo  Kazakhstan  Nepal  South Africa  South Africa

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above)  
☐ Yes  ☐ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?  
☐ Yes  ☐ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?  
☐ Yes  ☐ No

Have you ever resided or worked in a medically underserved area, a low income area or an area abusing drugs or alcohol which would be at risk for an increased incidence of latent *M. tuberculosis* infection or active TB disease?  
☐ Yes  ☐ No

If the answer is YES to any of the above questions, proceed to Part II of this form, found on the next page.

If the answer to all of the above questions is NO, no further testing or action is required.

Return this form to the Student Health Center along with page 1 of the Immunization Verification form.
Name: ____________________________  Student ID: ____________________________

**Part II. Clinical Assessment by Health Care Provider**

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below)  
☐ Yes  ☐ No

History of BCG vaccination? (If yes, consider IGRA if possible.)  
☐ Yes  ☐ No

1. **TB Symptom Check**
   Does the student have signs or symptoms of active pulmonary tuberculosis disease?  
☐ Yes  ☐ No

   If No, proceed to 2 or 3

   If yes, check below:
   ☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
   ☐ Coughing up blood (hemoptysis)
   ☐ Chest pain
   ☐ Loss of appetite
   ☐ Unexplained weight loss
   ☐ Night sweats
   ☐ Fever

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

2. **Tuberculin Skin Test (TST)** - Do Not do TST if history of previous positive TST – proceed to #3
   (TST result should 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.)**

   Date Given: ____/____/_____  Date Read: ____/____/_____

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

   **Risk-based interpretation of Tuberculin Skin Test**

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>POSITIVE RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV infected person or Close contact with a case Tuberculosis</td>
<td>5mm or more</td>
</tr>
<tr>
<td>Born in a country that has a high rate of Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Traveled or lived for one month or more in a country that has a high rate of Tuberculosis</td>
<td>10mm or more</td>
</tr>
<tr>
<td>None (test not recommended)</td>
<td>15 mm or more</td>
</tr>
</tbody>
</table>

   **CDC. Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. MMWR November 2005; 54 (No. RR-12): 4-5.**
Name: ___________________________________________  Student ID: ____________________________

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other____

M  D  Y

Result: negative___  positive___  indeterminate___  borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other____

M  D  Y

Result: negative___  positive___  indeterminate___  borderline___ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive) – Only Chest x-ray performed in the U.S. will be accepted

Date of chest x-ray: ____/____/____  Result: normal____  abnormal____

M  D  Y

Part III. Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with *M. tuberculosis* (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunoileal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol
- Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

_____ Student agrees to receive treatment

_____ Student declines treatment at this time

**Health Care Provider Signature**

Health Care Provider’s Name (please print) __________________________________________________________

Address: ______________________________________________________________________________________

Street  City  State  Zip code

Phone (_____)____________________  Fax (_____)____________________

Signature ___________________________________________  Date ________________