

MEDICAL ENTRANCE FORM (REQUIRED)

UNDER 18 YEARS OF AGE ONLY

Please upload completed form at www.immunizations.health.gatech.edu

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS

Semester Beginning: _____
GT ID#: _____ Cell Phone #: _____ Email: _____
Name (Last, First, Middle) _____
Address: _____ City: _____ State: _____ Country: _____
Zip Code: _____ Birth Date: _____

AUTHORIZATION TO TREAT

I hereby authorize the physicians, physician assistants and nurse practitioners of Stamps Health Services, including those at area hospitals, to perform diagnostic, preventative, and treatment procedures which in their judgment may be necessary while she/he attends Georgia Tech. I waive all claim to prior notification. I understand that every reasonable effort will be made to notify me in the event of a major illness or injury, or if the Stamps Health Services physician feels it is necessary.

Signature of parent/guardian: _____ **Date:** _____
Print Name: _____ **Relationship:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Country: _____ Zip Code: _____
Daytime phone: _____ Evening phone: _____ Email: _____

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Country: _____ Zip Code: _____
Daytime phone: _____ Evening phone: _____ Email: _____

CERTIFICATE OF REQUIRED IMMUNIZATIONS

Please upload completed forms at www.immunizations.health.gatech.edu

Please read ALL instructions below. Your records MUST meet these criteria to satisfy the requirements.

Semester Beginning: _____ Birth Date: _____ Country of Birth: _____
 GT ID#: _____ Cell Phone #: _____ Email: _____
 Name (Last, First, Middle) _____
 Address: _____ City: _____ State: _____ Zip Code: _____ Country: _____

Vaccine	Date MM/DD/YYYY	Date MM/DD/YYYY	Date MM/DD/YYYY		Date of Positive Lab/ Serologic Evidence(titer) ⁶
MMR (Measles, Mumps, Rubella) ¹	/ /	/ /			
or					
Measles ¹	/ /	/ /			/ /
+					
Mumps ¹	/ /	/ /			/ /
+					
Rubella ¹	/ /				/ /
Varicella ²	/ /	/ /			/ /
History of Disease Not Accepted					
Tetanus-Diphtheria-Pertussis (Whooping Cough) ³	/ / Tdap (required)	/ / Booster Td or Tdap (Circle One)			
Hepatitis B ⁴	/ /	/ /	/ /		/ /
Hep B or Twinrix (Circle One)					
Meningococcal ACWY ⁵ (Menactra or Menveo)	/ /	/ /			
Tuberculosis Screening (must be done within 6 months of the start of class)	U.S./Canadian Born Students - Complete Page 2 (TB Assessment, required) and Page 3 (Skin Test, if TB Assessment indicates at risk) International Born Students - Complete a QuantiFERON blood test (submit official lab report). If QuantiFERON test is positive Chest x-ray performed in the US is required.				

1-US/Canadian born students born in 1957 or later; All foreign born students regardless of year born; First dose must be after first birthday.

2-US/Canadian born students born in 1980 or later; All foreign born students regardless of year born; First dose must be after first birthday. History of disease not accepted.

3-**One dose of Tdap after 11th birthday is required for all students**; Td booster needed only if > 10 years since last Tdap or Td.

4-Hepatitis B vaccine or Hepatitis A-Hepatitis B (Twinrix) vaccine accepted. 0, 1, and 6 month schedule preferred.

5-**Vaccine required for all students under age 22. If vaccine given before 16th birthday, a booster dose on or after the 16th birthday is required.** This is not the same vaccine as the Meningococcal B vaccine (see recommended vaccines page).

6-Upload antibody titer reports; must be on lab letterhead or printed from an electronic medical record; must be in English and include definitive lab values with reference values. Lab/serologic evidence indicating immunity may be used in lieu of injections to verify immunity if immunization records incomplete.

SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED	
Name: _____ Signature: _____ Phone: _____ Date: _____	PHYSICIAN OFFICE STAMP

CERTIFICATE OF RECOMMENDED AND TRAVEL IMMUNIZATIONS

These immunizations are not required but recommended in some situations

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Semester Beginning: _____ Country of Birth: _____

GT ID#: _____ Cell Phone #: _____ Email: _____

Name (Last, First, Middle) _____

Address: _____ City: _____ State: _____ Country: _____

Zip Code: _____ Birth Date: _____

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY
HPV 4 or 9 (circle one)			
Meningococcal B <i>Not Menactra or Menveo</i>			
<i>Bexsero</i>			
<i>Trumenba</i>			
Hepatitis A			
Pneumovax			

Travel Immunizations

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY
Yellow Fever			
Typhoid Oral or Injection (Circle One)			
Polio Adult booster			
Japanese Encephalitis			
Rabies			

CERTIFICATION OF HEALTHCARE PROVIDER

Name: _____

Signature: _____

Phone: _____ Date: _____

Physician Office Stamp

TUBERCULOSIS (TB) ASSESSMENT FORM (REQUIRED)
US/CANADIAN BORN STUDENTS ONLY

Please upload completed form at www.immunizations.health.gatech.edu.

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

All international born students must receive a QuantiFERON test.

Semester Beginning: _____ Country of Birth: _____

GT ID#: _____ Birth Date: _____ Cell Phone #: _____ Email: _____

Name (Last, First, Middle) _____

Address: _____ City: _____ State: _____ Zip Code: _____ Country: _____

INSTRUCTIONS TO PROVIDER

TB assessment must be done within six (6) months prior to start of classes. **PLEASE NOTE:** TB skin tests, TB assessment and chest x-rays conducted outside of the United States of America or Canada will **NOT** be accepted under any circumstances. **If at risk, a tuberculin skin test or Quantiferon blood test must be completed within 6 months prior to the first day of class.**

History:

1. Have you ever had a positive TB skin test/QuantiFERON blood test? No Yes

Date of Positive PPD or QuantiFERON blood test: _____

2. Did you take medication(s) for the positive skin test or QuantiFERON? No Yes

If yes, please list dates of treatment and medication taken: _____

If student has had a positive TB skin test or Quantiferon test in the past, the student will need a chest x-ray done in the 6 months prior to the first day of class. An official report of the chest x-ray results will need to be uploaded. Chest x-rays performed outside of the United States or Canada will NOT be accepted.

<u>Symptom Risk:</u> Do you currently have any of the following symptoms?				<u>Symptom risk present?</u> (any question to the left answered yes)
3 weeks or more of Persistent Cough?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Unexplained weight loss?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Persistent Fever or Chills?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Persistent Night Sweats	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Loss of Appetite?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Coughing up blood?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<u>Exposure Risk:</u> Within the last 2 years, have you lived, worked, or volunteered in the following types of facilities?				<u>Exposure risk present?</u> (any question to the left answered yes)
Hospital?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Prison?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Homeless Shelter	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nursing Home?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Long Term Care Facility?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Residential Facility for patients with AIDS?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Rehabilitation Facility?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
<u>Travel Risks:</u>				<u>Travel risk present?</u> (Both questions to the left answered yes)
Have you lived or traveled outside of the US for greater than 2 weeks in the last 5 years?			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the country or countries where you have lived or traveled on the list of countries with moderate or high risk? (see accompanying list)			<input type="checkbox"/> No <input type="checkbox"/> Yes	
Countries traveled or lived in: _____				

If the student has any one of the risks in the right hand column above marked YES they will need a TB skin test (PPD) or a QuantiFERON test done.

CERTIFICATION OF HEALTHCARE PROVIDER AND DATE REQUIRED

Is this student at risk for TB Exposure? (One or more risk(s) in the right hand column of the table above present)

YES (complete TB Skin Testing Form) NO

Provider Name: _____ Date: _____ Phone # _____

Signature: _____

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Countries with moderate or high risk of TB:

Afghanistan	Congo	Kenya	New Caledonia	Sri Lanka
Algeria	Congo-Democratic Republic	Kiribati	Nicaragua	Sudan
Angola	Cote d'Ivoire	Korea-DPR	Niger	Suriname
Anguilla	Djibouti	Korea-Republic of	Nigeria	Swaziland
Argentina	Dominican Republic	Kuwait	Niue	Syrian Arab Republic
Armenia	Ecuador	Kyrgyzstan	Northern Mariana Islands	Tajikistan
Azerbaijan	El Salvador	Lao People's Democratic Republic	Pakistan	Taiwan
Bahrain	Equatorial Guinea	Latvia	Palau	Tanzania UR
Bangladesh	Eritrea	Lesotho	Panama	Thailand
Belarus	Estonia	Liberia	Papua New Guinea	Timor-Leste
Belize	Ethiopia	Libya	Paraguay	Togo
Benin	Fiji	Lithuania	Peru	Tokelau
Bhutan	French Polynesia	Madagascar	Philippines	Trinidad and Tobago
Bolivia	Gabon	Malawi	Poland	Tunisia
Bosnia and Herzegovina	Gambia	Malaysia	Portugal	Turkey
Botswana	Georgia	Maldives	Qatar	Turkmenistan
Brazil	Ghana	Mali	Romania	Turks and Caicos Islands
Brunei Darussalam	Greenland	Marshall Islands	Russian Federation	Tuvalu
Bulgaria	Guam	Mauritania	Rwanda	Uganda
Burkina Faso	Guatemala	Mauritius	Saint Vincent and the Grenadines	Ukraine
Burundi	Guinea	Mexico	Sao Tome and Principe	Uruguay
Cabo Verde	Guinea-Bissau	Micronesia (Federated States of)	Senegal	Uzbekistan
Cambodia	Guyana	Moldova-Republic of	Serbia	Vanuatu
Cameroon	Haiti	Mongolia	Serbia & Montenegro	Venezuela (Bolivarian Republic of)
Central African Republic	Honduras	Montenegro	Seychelles	Viet Nam
Chad	India	Morocco	Sierra Leone	Wallis and Futuna Islands
China	Indonesia	Mozambique	Singapore	Former Yugoslav Republic of Macedonia
China, Hong Kong SAR	Iran (Islamic Republic of)	Myanmar	Solomon Islands	Yemen
China, Macao SAR	Iraq	Namibia	Somalia	Zambia
Colombia	Japan	Nauru	South Africa	Zimbabwe
Comoros	Kazakhstan	Nepal	South Sudan	

TUBERCULOSIS (TB) SKIN TESTING FORM
(US/CANADIAN STUDENTS ONLY)

**RISK DETERMINED BY HEALTHCARE PROVIDER USING TB ASSESSMENT FORM **

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 GT ID#: _____ Cell Phone #: _____ Email: _____
 Name (Last, First, Middle) _____
 Address: _____ City: _____ State: _____ Country: _____
 Zip Code: _____ Birth Date: _____

TUBERCULIN SKIN TEST (Only accepted if completed in the US/Canada) TUBERCULIN SKIN TEST MUST BE COMPLETED WITHIN 6 MONTHS OF THE FIRST DAY OF CLASS.

Date placed _____ L / R Date read _____ (must be within 48 to 72 hours)
 MMDDYY MMDDYY
 Placed By: _____ Read By: _____
 Lot #: _____ Exp Date: _____ Result _____ mm (record actual mm of induration, transverse diameter. If no induration, record as "0 mm")
 MMDDYY
 *Declined due to QuantiFERON test completed: Date: _____

FINAL INTERPRETATION- Based on Criteria for Tuberculin Positivity below, by Risk Group **POSITIVE** **NEGATIVE**

Reaction > 5 mm of Induration	Reaction > 10mm of Induration	Reaction > 15mm of Induration
<ul style="list-style-type: none"> Human immunodeficiency virus (HIV)-positive persons Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of ≥ 15 mg/d of prednisone for 1 month or more) 	<ul style="list-style-type: none"> Recent immigrants to the U.S. (within the last 5 years) from high prevalence countries Persons with silicosis, diabetes, chronic renal failure, leukemias and lymphomas, carcinoma of the head, neck and lung, weight loss of ≥10% of ideal body weight, gastrectomy, and jejunioleal bypass 	<ul style="list-style-type: none"> Person with no risk factors for TB Persons who are otherwise at low risk and are tested at the start of employment, a reaction of ≥15 mm is considered positive
<ul style="list-style-type: none"> Fibrous changes on chest x-ray consistent with prior TB Recent contacts of infectious TB case 	<ul style="list-style-type: none"> Residents and employees of the high risk congregate settings. Mycobacterial laboratory personnel Injecting drug users Children less than 5 years of age or infants, children, and adolescents exposed to adults at high-risk Recent conversion (increase of ≥ 10 mm of induration within the past 2 years) 	

Chest X-RAY (Required if history of positive skin test, **Chest x-ray must be completed in the US/ Canada ONLY.** Chest x-ray must be performed after the date of the positive skin testing. XRAYs MUST BE COMPLETED WITHIN 6 MONTHS OF THE FIRST DAY OF CLASS. **Upload a copy of the chest x-ray report signed by the doctor.**

Date of chest x-ray _____ Date of Positive PPD: _____ Result: **NORMAL** **ABNORMAL**
 MMDDYY MMDYY

Treatment for latent TB

INH given? YES NO Rifampin YES NO

Other Treatment: _____

Duration of Treatment: From _____ to _____
 MMDDYY MMDDYY

SIGNATURE OF HEALTHCARE PROVIDER AND DATE REQUIRED

Provider Name: _____

Signature: _____

Phone: _____ Date: _____

PHYSICIAN OFFICE STAMP