Welcome to Georgia Tech! We are excited that you will be joining the Georgia Tech community in the coming months. This packet contains the immunization forms that can be used to complete your immunization requirements. It is very important that you first visit the website below and review the instructions found there so you will understand the steps you need to take to complete our immunization requirements.

https://health.gatech.edu/immunization-requirements/

If the instructions direct you to use these forms to complete your immunization requirements, please make note of the following items.

1. Please complete all personal information at the top of **each** page.
2. If you turn in immunization records that are not transferred onto our forms, you will likely miss completing one or more of our requirements. Most state immunization forms and previous college records may not include all our requirements.
3. Please allow 5 – 7 business days for processing once you submit your forms. We will contact you at your Georgia Tech email if any additional action is needed on your part.

We want the process of completing our immunization requirements to be easy for you.

After you review the instructions at the website above, please contact our immunization coordinator at immunizations@health.gatech.edu if you need any assistance.

GT Stamps Health Services

CERTIFICATE OF IMMUNIZATIONS (All Students)

Please upload completed forms and enter immunization dates at https://gatech.medicatconnect.com

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

Name (Last, First, Middle) ____ **Country of Birth:** _________________________

GT ID#: ____________________ Birth Date: _____________________Cell Phone #: ____________________________________

Semester Beginning: ______________________ Email: ____

Required Immunizations					
Vaccine	Injection 1 Date MM/DD/YYYY	Injection 2 Date MM/DD/YYYY	Injection 3 Date MM/DD/YYYY	OR	Lab Report Confirming Immunity
MMR (Measles, Mumps, Rubella)	/ /	/ /			
or					
Measles +	/ /	/ /		OR	Attach Lab Report in English
Mumps +	/ /	/ /		OR	Attach Lab Report in English
Rubella 2 doses on or after first birthday at least 28 days apart.	/ /			OR	Attach Lab Report in English
Varicella History of Disease Not Accepted 2 doses on or after first birthday at least 28 days apart.	/ /	/ /		OR	Attach Lab Report in English
Tetanus-Diphtheria-Pertussis Tdap on or after 10th birthday and Tetanus booster if > 10 years since Tdap dose	/ / Tdap on or after 10th birthday	/ / Tetanus booster if > 10 years since Tdap dose			
Hepatitis B ☐2 Dose Series (Heplisav-B) ☐3 Dose Hep B Series (0, 1, 6 month) ☐3 Dose Twinrix Series	/ /	/ /	/ /	OR	Attach Lab Report in English
Meningococcal ACWY Given on or after 16th birthday Required for those under age 22	/ /	/ /			
Tuberculosis Screening (must be completed no more than 6 months prior to the start of class)	**U.S./Canadian Born Students** – Complete a Tuberculosis screening form on the Forms page of our Patient Portal (https://gatech.medicatconnect.com). If you are at risk for Tuberculosis, the form will provide you with further instructions. **International Born Students** - Complete an IGRA (Interferon Gamma Release Assay) blood test. If IGRA test is positive, Chest x-ray performed in the US is required. If receiving live vaccines at the same time as IGRA testing, IGRA test must be performed on the same day as the live vaccines or 28 days later. **Attach IGRA lab report in English.**				

Recommended Vaccines				
Hepatitis A		/ /	/ /	
HPV		/ /	/ /	/ /
Covid-19	**Brand:**	/ /	/ /	/ /
	Brand:	/ /	/ /	/ /
Meningococcal B	**Bexsero**	/ /	/ /	
	Trumenba	/ /	/ /	/ /

SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED

Name: ____

Signature: ____

Phone: ____________________ **Date:**________________

PHYSICAN OFFICE STAMP

Stamps Health Services

MEDICAL ENTRANCE FORM (REQUIRED)

UNDER 18 YEARS OF AGE ONLY

Please upload completed form at https://gatech.medicatconnect.com

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: ____________________________________