MEDICAL ENTRANCE FORM (REQUIRED)

UNDER 18 YEARS OF AGE ONLY

(If over 18, continue to page 2)

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: ___________________________________

Georgia Tech Stamps Health Services Campus Services

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	Injection 1 Date MM/DD/YYYY	Injection 2 Date MM/DD/YYYY	Injection 3 Date MM/DD/YYYY	OR	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) 2 Dose or 3 Dose Series (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 4 (TB Assessment, required) and Page 6 (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. QuantiFERON must be performed on the same day any live vaccines are administered **or** at least 28 days after any live vaccines are administered.				

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 10th 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:** ________________

PHYSICAN OFFICE STAMP

Georgia Tech Stamps Health Services Campus Services

CERTIFICATE OF RECOMMENDED AND TRAVEL IMMUNIZATIONS

These immunizations are not required but recommended in some situations

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

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS

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 *Not Menactra or Menveo*			
Bexsero			
Trumenba			
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

Effective Date of Revision 11/16/2015

Georgia Tech | Stamps Health Services | Campus Services

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.

Symptom Risk: Do you currently have any of the following symptoms?							**Symptom risk present?**
3 weeks or more of Persistent Cough?	☐ No	☐ Yes	Unexplained weight loss?	☐ No	☐ Yes		(any question to the left answered yes)
Persistent Fever or Chills?	☐ No	☐ Yes	Persistent Night Sweats	☐ No	☐ Yes		☐ No ☐ Yes
Loss of Appetite?	☐ No	☐ Yes	Coughing up blood?	☐ No	☐ Yes		
Exposure Risk: Within the last 2 years, have you lived, worked, or volunteered in the following types of facilities?							**Exposure risk present?** (any question to the left answered yes)
Hospital?	☐ No	☐ Yes	Prison?	☐ No	☐ Yes		
Homeless Shelter	☐ No	☐ Yes	Nursing Home?	☐ No	☐ Yes		☐ No ☐ Yes
Long Term Care Facility?	☐ No	☐ Yes	Residential Facility for patients with AIDS?	☐ No	☐ Yes		
Rehabilitation Facility?	☐ No	☐ Yes					
Travel Risks:							**Travel risk present?** (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?				☐ No	☐ 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)				☐ No	☐ Yes		☐ No ☐ 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: ______________________________

Georgia Tech | Stamps Health Services | Campus Services

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

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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	

Georgia Tech | Stamps Health Services
Campus Services

TUBERCULOSIS (TB) SKIN TESTING FORM

(US/CANADIAN STUDENTS ONLY)

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

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

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

Semester Beginning: ______________ Country of Birth: ______________________________

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
MMDDYY

Date read__________ (must be within 48 to72 hours)
MMDDYY

Placed By: ___________________________________

Read By: ___________________________________

Lot #: _____________ Exp Date: ___________
MMDDYY

Result __________mm (record actual mm of induration, transverse diameter. If no induration, record as "0 mm")

Declined due to QuantiFERON test completed: Date:_______________ (attach the official lab report)

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
• Human immunodeficiency virus (HIV)-positive persons	• Recent immigrants to the U.S. (within the last 5 years) from high prevalence countries	• Person with no risk factors for TB
• Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of $\geq$ 15 mg/d of prednisone for 1 month or more	• Persons with silicosis, diabetes, chronic renal failure, leukemias and lymphomas, carcinoma of the head, neck and lung, weight loss of $\geq$10% of ideal body weight, gastrectomy, and jejunoileal bypass	• Persons who are otherwise at low risk and are tested at the start of employment, a reaction of $\geq$15 mm is considered positive
• Fibrous changes on chest x-ray consistent with prior TB	• Residents and employees of the high risk congregate settings.	
• Recent contacts of infectious TB case	• 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 $\geq$ 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: ___________