Student Health
VIRGINIA WESLEYAN UNIVERSITY

VIRGINIA WESLEYAN UNIVERSITY IMMUNIZATION RECORD

Return completed form by email to **studenthealth@vwu.edu**.

TO BE COMPLETED AND SIGNED BY MEDICAL PERSONNEL

STUDENT INFORMATION

Student Name:	VWU ID:
Date of Birth:	Email:
Phone:	Entering Semester/Year: ☐ Spring ☐ Fall 20___

PART 1 - IMMUNIZATION

A. Measles, Mumps, Rubella *(required)*

1. I was born before January 1, 1957 and am considered immune ☐ Yes ☐ No (If no, please complete #2 or #3)

OR

2. MMR (Measles, Mumps, Rubella)
   Two doses are required: 1st Dose: ____/____/_____ 2nd Dose: ____/____/_____

OR

All 3 of three following criteria are met:

3. Measles (Rubeola)
   Positive immune titer ___/___/____ **OR** two doses of individual rubeola vaccine ___/___/____ ___/___/____

   Mumps
   Positive immune titer ___/___/____ **OR** one dose of individual mumps vaccine ___/___/____

   Rubella (German measles)
   Positive immune titer ___/___/____ **OR** one dose of individual mumps vaccine ___/___/____

B. Tetanus-Diphtheria *(required)*

Must be within the last ten (10) years: ___/___/____ **OR** Tdap ___/___/____

C. Poliomyelitis *(required)*

1. Primary childhood series - completed: ___/___/____ **OR**
2. Positive immune titer ___/___/____ **OR** One dose of IPV - completed ___/___/____

D. Hepatitis B – Vaccine or Waiver Required

1. Immunization (Hepatitis B): Dose #1 ___/___/____ Dose #2 ___/___/____ Dose #3 ___/___/____

OR

2. Immunization (combined Hepatitis A & B vaccine)
   Dose #1 ___/___/____ Dose #2 ___/___/____ Dose #3 ___/___/____

OR

WAIVER: I have reviewed the CDC website regarding Hepatitis B at http://www.cdc.gov/hepatitis/index.htm and have been fully informed of the risks and health hazards of Hepatitis B infection as well as the benefits of the Hepatitis B vaccine. I choose not to be immunized by Hepatitis B infection at this time.

Signature of waiver (student, if under 18 years parent/legal representative): _____

E. Meningococcal Vaccine

1. Date of vaccination: ___/___/____ Menveo _____ Menactra _____

A booster dose is recommended (or a signed waiver) for those who received their first dose before age 16.

OR

WAIVER: I have reviewed the CDC website regarding Meningitis at http://www.cdc.gov/meningitis/index.htm and have been fully informed of the risks and health hazards of Meningitis infection as well as the benefits of the Meningitis vaccine. I choose not to receive the Meningitis vaccine.

Signature of waiver (student, if under 18 years parent/legal representative): _____

CONTINUE TO PAGE 2 FOR REQUIRED SIGNATURE

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PART 2 - TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active TB disease? ☐ Yes ☐ No

If NO, proceed to question 2

If YES, proceed with additional evaluation to exclude active TB disease, including TB skin testing, chest x-ray, and sputum evaluation as indicated.

2. Is the student a member of a high-risk group? ☐ Yes ☐ No

Categories of high-risk students include students who have arrived in the last 5 years from countries where TB is endemic.

If NO, no further evaluation necessary.

If YES, Please report the necessary steps taken on #3 and/or #4 (i.e. chest x-ray, or PPD result)

3. Tuberculin Skin Test (**must have been placed within the last 12 months**)

Date Given ___/___/____ Date Read ___/___/____

Result: _____ Interpretation: ☐ Positive ☐ Negative

4. Chest x-ray (required if tuberculin skin test is positive)

Date Given ___/___/____ Result: ☐ Positive ☐ Negative

REQUIRED SIGNATURE:

Signature OR Signature Stamp of Licensed Health Professional **Date**

Print Name & Title **Address** **Phone**