

Immunization Verification

All students must complete this form and return it to the

Student Health Center by July 24, 2017

health_center@redlands.edu • 1200 E. Colton Ave. Redlands, CA. 92373-0999

Tele: (909) 748-8021 • Fax: (909) 335-5117

Student Information:

Name: _____

Student ID: _____

Birth Date: _____

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.

NOTE: **ALL BLANKS MUST BE COMPLETED.** Students with missing or incomplete forms after the deadline may be subject to a \$250 fine. Additional information about the vaccine requirements is provided on pages 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

STUDENTS WITH MISSING OR INCOMPLETE FORMS AFTER THE DEADLINE MAY BE SUBJECT TO A \$ 250 FINE

Immunization Verification

All students must complete this form and return it to the

Student Health Center by July 24, 2017

health_center@redlands.edu • 1200 E. Colton Ave. Redlands, CA. 92373-0999

Tele: (909) 748-8021 • Fax: (909) 335-5117

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.

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 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, Diphtheria and Pertussis (Tdap) or Tetanus-Diphtheria (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).

Immunization Verification

All students must complete this form and return it to the

Student Health Center by July 24, 2017

health_center@redlands.edu • 1200 E. Colton Ave. Redlands, CA. 92373-0999

Tele: (909) 748-8021 • Fax: (909) 335-5117

Name: _____

Student ID: _____

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, the University of Redlands requires that you receive TB testing as soon as possible.

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 further 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 country, below)

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata>.

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 been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? Yes No

If the answer is YES to any of the above questions, the University of Redlands requires that you receive TB testing as soon as possible.

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 further action is required.

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

Immunization Verification

All students must complete this form and return it to the

Student Health Center by July 24, 2017

health_center@redlands.edu • 1200 E. Colton Ave. Redlands, CA. 92373-0999

Tele: (909) 748-8021 • Fax: (909) 335-5117

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: ____/____/____
 M D Y

Date Read: ____/____/____
 M D Y

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

Risk-based interpretation of Tuberculin Skin Test

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

¹ 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.

Immunization Verification

All students must complete this form and return it to the

Student Health Center by July 24, 2017

health_center@redlands.edu • 1200 E. Colton Ave. Redlands, CA. 92373-0999

Tele: (909) 748-8021 • Fax: (909) 335-5117

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 jejunioileal 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 _____