RHODES IMMUNIZATION RECORD

Students and parents; please read the information on Hepatitis B and Meningitis Vaccines.
Fill in the dates vaccines were received or sign the waivers.

Return this form to Rhodes College, Student Health Center
2000 N. Parkway, Memphis, TN 38112 FAX: 901-843-3134

Student's Name _____ SS Number _____

The General Assembly of the State of Tennessee mandates that each post-secondary institution in the state provide information concerning Hepatitis B infection to all students entering the institution for the first time. Those students who will be living in on-campus housing must also be informed about the risk of meningococcal infection. The required information below includes the risk factors and dangers of each disease as well as the information on the availability and effectiveness of the respective vaccines for persons who are at-risk for the diseases. The information concerning these diseases is from the Centers for Disease Control and Prevention and the American College Health Association.

The TN law requires that all new in-coming students either receive the vaccinations (as outlined below) or sign a waiver indicating that they do not wish to receive the vaccines.

A. Hepatitis B (HBV) Immunization
[TO BE COMPLETED BY ALL NEW IN-COMING STUDENTS - MANDATORY]

Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. The disease is transmitted by blood and/or body fluids and many people will have no symptoms when they develop the disease. The primary risk factors for Hepatitis B are sexual activity and injection drug use. This disease is completely preventable. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infection. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be administered to complete the series if only one or two have been previously received. The HBV vaccine has a record of safety and is believed to confer lifelong immunity in most cases.

_____ I hereby certify that I have read this information and **I have received the initial dose of the Hepatitis B vaccine. Supply vaccine information on the health questionnaire.**
_____ I hereby certify that I have read this information and **I have elected NOT to receive the Hepatitis B vaccine.**

Signature of **Student** (or **Parent/Guardian** if student is under 18): _____ Date: _____

B. Meningococcal Meningitis Vaccine
[TO BE COMPLETED BY ALL NEW INCOMING STUDENTS- MANDATORY]

Meningococcal disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococcemia (bacteria in the blood). Meningococcal disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually. The disease is spread by airborne transmission, primarily by coughing. The disease can onset very quickly and without warning. Rapid intervention and treatment is required to avoid serious illness or death. There are 5 subtypes (serogroups) of the bacterium that causes Meningococcal Meningitis. The current vaccines do not stimulate protective antibodies to serogroup B, but both protect against the most common strains of the disease, serogroups A, C, Y and W-135. The duration of protection is approximately 3 to 5 years for ***Menomune*** and even longer for the conjugate vaccine ***Menactra***. The vaccines are very safe and adverse reactions are almost always mild and local, consisting primarily of redness and pain at injection site lasting up to two days. The Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) recommends that college freshman (particularly those who live in dormitories or residence halls) be informed about meningococcal disease and the benefits of vaccination and those students who wish to reduce their risk for meningococcal disease be immunized. Other undergraduate students who wish to reduce their risk for meningococcal disease may also chose to be vaccinated.

_____ I hereby certify that I have read this information and **I have received the vaccine for Meningococcal Meningitis. Supply vaccine information on the health questionnaire.**
_____ I hereby certify that I have read this information and **I have elected NOT to receive the vaccine for Meningococcal Meningitis.**

Signature of **Student** (or **Parent/Guardian** if student is under 18): _____ Date: _____

For more information about Meningococcal Meningitis and hepatitis B disease and vaccine, please contact your local health care provider or consult the Centers for Disease Control and Prevention web site at www.cdc.gov.

RHODES IMMUNIZATION RECORD

Page 2 of 4

This form MUST be completed and signed by your physician. All information must be in English.

Return this form to Rhodes College, Student Health Center
2000 N. Parkway, Memphis, TN 38112 FAX: 901-843-3134

Student's Name _____ SS Number _____

REQUIRED IMMUNIZATIONS	DATE ADMINISTERED(MM/DD/YR)
1. TETANUS-DIPHTHERIA-PERTUSSIS (required for all students) **dT booster within 10 yrs……..** OR **Tdap within past 10 yrs……...**	_____-_____-_____ **OR** _____-_____-_____
2. HEPATITIS B (waiver or vaccination required) **Dose #1……** **Dose #2 (1-2 mo after 1st)……** **Dose #3 (4-6 mo after 1st)……**	 **#1** _____-_____-_____ **#2** _____-_____-_____ **#3** _____-_____-_____
3. M.M.R. (MEASLES, MUMPS, RUBELLA) **(Two doses required at least 28 days apart for students born after 1956.)** **1. Dose 1 given at age 12 months or later……** **2. Dose 2 given at least 28 days after first dose……**	 **#1** _____-_____-_____ **#2** _____-_____-_____
4. MENINGOCOCCAL (waiver or vaccination required) **Should be repeated every 5 yrs if risk persists (i.e. travel needs)**	**Menactra** _____-_____-_____ **OR** **Menomune** _____-_____-_____
5. POLIO (primary series required for all students) **Date of last dose……**	☐ **IPV** _____-_____-_____ ☐ **OPV**
6. VARICELLA **History of Disease Yes ☐ No ☐** **If No History of Disease:** **1. Varicella Antibody Titer ___ - ___ - ___ Result: Positive ____ Negative ___** **OR M D Y** **2. Immunization required if titer negative and no disease history** **Dose #1……** **Dose #2 given at least 4 weeks after first……**	 **#1** _____-_____-_____ **#2** _____-_____-_____
RECOMMENDED IMMUNIZATIONS	**DATE ADMINISTERE(MM/DD/YR)**
HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4) (Three doses of vaccine for female or male college students 11-26 years of age at 0, 1-2, and 6 month intervals.)	**#1** _____-_____-_____ ☐ **Quadrivalent (HPV4)** **#2** _____-_____-_____ **OR** ☐ **Bivalent** **#3** _____-_____ **(HPV2)**
2. HEPATITIS A (strongly recommended for all students, but not required) **Dose #1……** **Dose #2 (given 6-12 mo after first)……**	**#1** _____-_____-_____ **#2** _____-_____-_____

Examining Physician

Name _____ Address _____

Signature _____ Phone _____

RHODES IMMUNIZATION RECORD

This form is to be completed by the incoming student or parent. All information must be in English.

Return this form to Rhodes College, Student Health Center
2000 N. Parkway, Memphis, TN 38112 FAX: 901-843-3134

Student's Name _____ SS Number _____

Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:
Have you ever had a positive TB skin test? Yes ___ No ___
Have you ever had close contact with anyone who was sick with TB? Yes ___ No ___
Have you ever been vaccinated with BCG? Yes ___ No ___
Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? Yes ___ No ___
(If yes, please CIRCLE the country)
Have you ever traveled** to/in one or more of the countries listed below? Yes ___ No ___
(If yes, please CHECK the country/ies)
Have you been a resident, employee, or volunteer in a high-risk congregate setting? Yes ___ No ___
(correctional facilities, nursing homes, homeless shelters, hospitals, other health care facilities)

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

Source: World Health Organization, Global Health Observatory, Tuberculosis Incidence 2009. Countries with incidence rates of ≥ 20 cases per 100,000 population. For further updates, refer to http://apps.who.int/ghodata/?vid=510

If the answer is <u>YES</u> *to any* of the above questions, a physician **<u>MUST</u>** complete page 4 of the Immunization Record.
If you answered <u>NO</u> *to all* of the above questions, do **<u>NOT</u>** complete page 4.

Student Signature _____

RHODES IMMUNIZATION RECORD

This form **MUST** be completed and signed by your physician if you answered **YES** *to any* of the questions on page 3. All information must be in English.

Return this form to Rhodes College, Student Health Center
2000 N. Parkway, Memphis, TN 38112 FAX: 901-843-3134

Student's Name _____ SS Number _____

TUBERCULSIS (TB) RISK ASSESSMENT

Persons with any of the risk factors from page 3 of the Immunization Record, are required to have either a TB skin test (PPD) or Interferon Gamma Release (IGRA). If a previous positive test has been documented, please provide proof of a current normal chest x-ray or documentation of treatment.

Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____

1. Tuberculin Skin Test (TST)

(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: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration Interpretation: positive____ negative____

****Interpretation guidelines**

>5 mm is positive:

· Recent close contact of an individual with infectious TB
· Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
· Organ transplant recipients
· Immunosuppressed persons: taking > 15mg/d of prednisone for > 1 month; taking a TNF-a antagonist
· Persons with HIV/AIDS

>10mm is positive:

· Persons born in a high prevalence country or who resided in one for a significant* amount of time
· History of illicit drug use
· Mycobacteriology laboratory personnel
· History of resident, worker or volunteer in high-risk congregate settings
· Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15mm is positive:

· Persons with no known risk factors for TB disease

2. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/___/___ (specify method) QFT-G QFT-GIT other_____
M D Y

Result: Negative___ Positive___ Intermediate___

If the results are positive, proceed to 4

3. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Examining Physician

Name _____ Address _____

Signature _____ Phone _____