KENNESAW STATE UNIVERSITY
DIVISION OF ENROLLMENT SERVICES
Office of The Registrar

CERTIFICATE OF REQUIRED IMMUNIZATIONS
Office of the Registrar
Submit to: https://immunizations.kennesaw.edu/index.php
585 Cobb Avenue NW Room 1533, MD 0116 Kennesaw, GA 31044
RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS

KSU ID#: 00_____ Cell Phone: _____ Email: _____
Name (Last, First, Middle): _____
Address: _____ City: _____ State: _____ Zip Code: _____
Country of Birth:_____ Birth Date:_____

REQUIRED IMMUNIZATIONS	REQUIREMENT (MM/DD/YYYY)	REQUIRED FOR:
MMR (Measles, Mumps, Rubella) **OR**	#1 _____ #2 _____	• All foreign born students regardless of year born • US/Canadian students born in 1957 or later • 1st due at 12 months of age or older • 2nd dose administered no earlier than 28 days after 1st dose
• Measles (Rubeola) AND • Mumps AND • Rubella (German Measles)	#1_____#2 _____ **OR** Attached antibody titer (blood test) lab report **AND** #1_____#2 _____ **OR** Attached antibody titer (blood test) lab report **AND** #1 _____#2_____ **OR** Attached antibody titer (blood test) lab report.	• US/Canadian students born in 1957 or later • If Antibody titer does not indicate immunity, injection seriesrequired. • **You <u>must</u> submit the antibody titer report on lab letterheadfrom a certified lab with definitive lab values in English.** • 1st due at 12 months of age or older • 2nd dose administered no earlier than 28 days after 1st dose
Varicella (Chicken Pox)	#1_____#2 _____ **Or** Attached antibody titer (blood test) lab report **Or** Definitive diagnosis of varicella by healthcareprovider (history of disease reported to provider not sufficient). Provide statement from provider verifying previous infection.	• **<u>SELF/PARENTAL REPORTED HISTORY OF DISEASENOT ACCEPTED</u>** • All foreign born students regardless of year born. • US/Canadian born students born during or after 1980. • 1st due at 12 months of age or older • 2nd dose administered no earlier than 28 days after 1st dose • If Antibody titer does not indicate immunity, injection seriesrequired. • **You <u>must</u> submit the antibody titer report on lab letterheadfrom a certified lab with definitive lab values in English.**
Tetanus, Diphtheria, Pertussis(Tdap)	Tdap_____**(REQUIRED)**	• One dose of Tdap for all students. Must have occurred within the last ten years. Preferably administered after 11th birthday.
Hepatitis B OR **Hep A-Hep B (Twinrix)**	#1 _____ #2 _____ #3 _____ **OR** Attached antibody titer (blood test) lab report	• All Students who will be 18 or younger on the first day of class. • If Antibody titer does not indicate immunity, injection seriesrequired. • **You <u>must</u> submit the antibody titer report on lab letterheadfrom a certified lab with definitive lab values in English.**
Meningococcal (MCV4)	Menactra or Menveo _____ **Or** Menactra or Menveo Booster, if first dose was less than 5 years from admittance _____	• All students living in in KSU Campus Housing • A student may sign a statement of understanding in lieu of providing proof of immunization. • It is **strongly** recommended for all students under the age of 22.

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RECOMMENDED IMMUNIZATION	RECOMMENDED (MM/DD/YYYY)	RECOMMENDED FOR:
Human Papillomavirus[5]	#1 _____ #2_____ #3_____	• Strongly recommended for all unvaccinated males and females through age 26 years
Hepatitis A	2 Dose Series #1_____ #2_____ **OR** 3 Dose Series #1_____ #2_____ #3_____ **OR** Date of Positive Lab Result_____	• Strongly recommended but not required for: persons traveling to countries where hepatitis A is moderately or highly endemic, men who have sex with men, users of injectable and noninjectable drugs, persons with clotting factor disorders, and persons with chronic liver disease.
Meningococcal B	2 Dose Series #1_____ #2_____ OR 3 Dose Series #1_____ #2_____ #3_____	• Consider if younger than 23 years of age
Annual Influenza	#1_____ #2_____	• Strongly recommended for students with medical conditions such as diabetes, asthma, or immunodeficiencies, as well as for students residing in dormitories or other group living situations or who are members of athletic teams.
Pneumococcal Polysaccharide	#1_____	• 1 dose for persons < 65 yrs if have chronic illness or other risk factors including but not limited to: diabetes, asthma, asplenia, sickle cell disease, cochlear implant recipient, HIV infection or other immunocompromising condition OR • 1 dose for unvaccinated persons > 65 yrs. • Revaccination with pneumococcal polysaccharide vaccine every 5 yrs after persons is 65 yrs, is NOT recommended
Tuberculosis (TB)	Complete the **Tuberculosis Screening Questionnaire** found on page 3.	• If the answer to any of the TB screening questions is YES, then the TB skin test or IGRA needs to be completed by a physician.

PERMANENT OR TEMPORARY IMMUNIZATION MEDICAL EXEMPTION

___This student is exempt from the above immunizations on the ground of permanent medical contraindication.

___This student is temporarily exempt from the above immunization until _____/_____/____.

SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED

Name: _____
Signature:_____
Address:_____
Phone:_____**Date:**_____

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Name (Last, First, Middle): _____

TUBERCULOSIS RISK ASSESSMENT – TO BE COMPLETED BY A HEALTHCARE PROVIDER

Tuberculosis (TB) Screening Questions:

☐ **Yes** ☐ **No** **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥ 2 years old

☐ **Yes** ☐ **No** **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Yes** ☐ **No** **Close contact** to someone with infectious TB disease during lifetime

IF you checked YES to any of the previous TB screening questions, then the student needs a TB skin test or IGRA.

Tuberculosis Screening

➢ History of (+) PPD or IGRA (circle one)?

☐**Yes, hx of + PPD of IGRA** Date:____/____/_____ (_____mm induration if PPD**)

➢ Treatment completed? ☐Yes, date: ____/____/_____ ☐No

➢ If + PPD or IGRA, chest x-ray required within the last 3 months:

Date:_____/_____/_____ ☐Normal ☐Abnormal

☐**No past hx of + PPD or IGRA:**

➢ IGRA or PPD (circle one) required within the last 3 months, regardless of BCG history:

Date:____/____/_____

IGRA ☐Pos ☐Neg

OR

PPD ☐Pos ☐Neg _____mm induration**

➢ Newly documented positives also require chest-x-ray within the last 3 months:

Date:____/____/_____ ☐Normal ☐ Abnormal

Treatment started? ☐Yes, date: _____/_____/_____ ☐No

	***PPD Interpretation Guidelines	
> 5 mm is positive: • **Recent close contact with person with active TB** • **Abnormal CXR c/w past TB disease** • **Organ transplant or other immunosuppressionH IV/AIDS**	**>10 mm is positive:** • **Significant travel or residence in high prevalence area** • **Illicit drug use** • **Worker in healthcare, homeless shelter, prisons** • **Chronic Health Issues, as per above screening questions**	**>15 mm is positive if no risk factors**

SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED

Name: _____
Signature:_____
Address:_____
Phone:_____**Date:**_____

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