# University of Colorado Anschutz Medical Campus
# Colorado School of Public Health
# Student Immunization Certification

**Please mail/fax completed form signed by both the student and the health care certifying official at least two weeks prior to the start of your first semester:** Office of Student Affairs, Colorado School of Public Health, University of Colorado, Anschutz Medical Campus, 13001 East 17th Place, Campus Box B-119, Aurora, CO 80045. Fax: 303.724.4620

****Please maintain a copy for your personal records****

**Student's Name:** **Date of Birth:** **Degree/Program:** **Student ID #:**

**Email Address:** **Phone Number:**

**The following immunizations are required of all entering Anschutz Medical Campus (AMC) Graduate Students. AMC follows the Center for Disease Control (CDC) Guidelines are listed with each immunization. THE CERTIFYING OFFICIAL MUST list the dates immunizations or titers were received for the following:**

| MEASLES, MUMPS, RUBELLA (MMR): | | | | | |
|---|---|---|---|---|---|
| 1st Measles Vaccine: / / | 2nd Measles Vaccine: / / | **OR** | Date of Titer: / / | **Titer Result:** | |
| 1st Mumps Vaccine: / / | 2nd Mumps Vaccine: / / | **OR** | Date of Titer: / / | **Titer Result:** | |
| 1st Rubella Vaccine: / / | 2nd Rubella Vaccine: / / | **OR** | Date of Titer: / / | **Titer Result:** | |

**MEASLES, MUMPS, RUBELLA (MMR):** Documentation of 2 shots or serologies is required. Measles, mumps and rubella require individual titers. List either the **two** dates of the MMRs received or the **individual** titer dates and results. The first MMR must have been received on or after your first birthday and there must be at least 28 days between the first and second MMR. If received prior to your first birthday or there is less than 28 days between the two MMRs received, you are required to have another MMR or show proof of positive titers.

**TO BE COMPLETED BY CERTIFYING OFFICIAL* The certifying official does NOT certify that they have given all immunizations listed, but that they have seen written documentation the immunizations were received.**

Print Name (* MD, DO, NP, PA, RN):_____ Title: _____

Signature of person listed above: _____ Contact Number: _____ Date signed: _____

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***Medical Exemption:*** The physical condition of the above-named person is such that immunization would endanger life or health, or is medically contraindicated due to medical conditions. Physician's Name (please print) _____ Physician's Signature: _____

Date signed: _____ Contact Number: _____ Email Address: _____

***Religious Exemption:*** Parent or guardian of the above-named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

Relationship and printed name of person signing this form: _____ Date signed: _____

Signature of Person Signing this form: _____ Contact Number: _____

***Personal Exemption:*** Parent or guardian of the above-named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

Relationship and printed name of person signing this form: _____ Date signed: _____

Signature of Person Signing this form: _____ Contact Number: _____

**IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS WILL BE SUBJECT TO EXCLUSION FROM SCHOOL AND QUARANTINE**

**Please be advised, by signing an exemption students may be subject to academic restrictions regarding lab and/or clinical placement and may be unable to complete their program/degree requirements.**

**TO BE COMPLETED BY STUDENT -** I understand that if my immunizations are not current or are in progress while in attendance at UCDAMC, I may be subject to academic restrictions and may not be able to complete program/degree requirements. I authorize HSC to disclose this form and/or other information related to my immunization records to any clinical agency or other such entity in connection with my placement or participation in clinical internships, practica, affiliations and other programs related to my course of study.

Student Signature: _____ Contact Number: _____ Date signed: _____

**FOR HSC USE ONLY:** By signing below I certify this student has completed all necessary immunization requirements to matriculate.

Signature of HSC Official reviewing form: _____ Date reviewed: _____

**ADDITIONAL IMMUNIZATIONS NOT REQUIRED (While these immunizations are not required for admission, if you have received any of the immunizations listed below, please fill in the dates.)**

| **HEPATITIS B:** | | | | | |
|---|---|---|---|---|---|
| **1st:** / / | **2nd:** / / | **3rd:** / / | **OR** | **Date of Titer:** / / | **Titer Result:** |

**HEPATITIS B:** to be fully immunized you would need to have had a three shot series or have a positive HBSAB titer result 1-2 months after the third dose. Please provide the date vaccines were received or the titer and result. There must be at least 4 wks between the first and second vaccine and 4 - 5 months between the second and third vaccine (given at 0, 1, and 6-month intervals. If there is less than 4 weeks between vaccines 1 and 2 or less than 4 months between vaccines 2 and 3 or more than one year between vaccine 1 and 3, you are required to show proof of a positive HBSAB titer. If you have a negative titer, you are required complete the three dose series, if the second titer is still negative after 6 doses of vaccine the patient is a non-responder.

**TETANUS (Td/Tdap): (must be within the last 10 years.)** Date current tetanus shot received: / /

TETANUS: After primary vaccination, a tetanus-diphtheria (Td) booster is required for all healthcare workers every 10 years.
**FOR INTERNATIONAL STUDENTS:** three documented doses of TD are required. Primary vaccination of previously unvaccinated adults consists of three doses of adult tetanus-diphtheria toxoid (Td): 4-6 weeks should separate the first and second dose; the third dose should be administered 6-12 months after the second.

| **VARICELLA (Chickenpox):** | | | | | | |
|---|---|---|---|---|---|---|
| Date of Disease (Year): | **OR** | Titer Date: / / | Result: | **OR** | 1st Vaccine: / / | 2nd Vaccine: / / |

**VARICELLA:** please list the date (year) you had varicella (chickenpox), or the titer date and result or dates vaccine received. A negative titer requires two vaccines placed one month apart.

| POLIO: (Documentation for Domestic Students is strongly preferred however documentation of Polio is required for all International Students) | | | |
|---|---|---|---|
| **1st:** / / | **2nd:** / / | **3rd:** / / | 4th: / / |

**POLIO:** list the dates of the four-shot childhood series. Adults, who had 1 or 2 IPV doses, and no documentation of childhood series, should complete a total of 2 booster doses.

## Colorado School of Public Health/AMC Immunization Program
## Tuberculosis Information and Screening Form

**Last Name:** _____ _____ _____ **Date** ___ / ___ / _____
*Last* *First* *MI*

**SID#** **Where were you born?** USA ____ Other Country_____
*Name of Country*

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*Please circle.*

1. Have you ever had a **positive** Tuberculosis Skin Test (PPD**)**? Yes No

2. Have you ever been given **medicine(s)** to prevent or treat active Tuberculosis? Yes No
   If yes, which medicine did you take? _____
   For how long? _____

3. Have you ever had a **BCG** (immunization for Tuberculosis)? Yes No
   If yes, how old were you? _____

4. Have you ever had **close contact** with a person with active Tuberculosis? Yes No

5. Have you ever **worked or lived in** a nursing home, jail, or homeless shelter? Yes No

6. Have you ever **traveled or lived in** Eastern Europe, Asia, Russia, Africa, or Latin America for more than **two months?** If so, where? _____ Yes No

7. Have you recently had any of the following **symptoms** for no good reason? Yes No
   (**Please circle all that apply.)**
   *Night sweats* *Fatigue/Tiredness* *Fevers Weight Loss*
   *Poor Appetite* *Coughing up blood* *Cough for more than 3 weeks*

8. Have you ever been diagnosed with a **chronic medical condition** that may impair your immune system? Yes No

*I give consent to release my Tuberculosis information to the Colorado School of Public Health*

***Patient's Signature:*** _____ ***Date*** _____
***(Parent/guardian signature if under 18 years of age)***

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**If you answered "yes" to any of questions 3 – 8, you must have a Tuberculosis Skin Test (PPD)**

*The following information must be completed by* ***a Physician's office.***

! **Tuberculin Skin Test** (Mantoux only; no tine tests) A two-step PPD is required if you answered yes to any of questions 3-8 above. A single TB skin test administered after the initial exposure may elicit a negative response. The immune reaction wanes over time. Giving a second test stimulates the immune system to respond and may respond positively, indicating that the person was previously infected or exposed. It is important to differentiate between old and new infection. Please list the dates and a result for **BOTH** PPDs received:

Date given: ___/___/___ Date read: ___/___/___
Result: _____ (Record actual mm of induration, transverse diameter: if no induration, write "O")

Date given: ___/___/___ Date read: ___/___/___
Result: _____ (Record actual mm of induration, transverse diameter: if no induration, write "O")
Interpretation (based on mm of induration as well as risk factors): *Positive Negative*

! **Chest x-ray** (required if tuberculin skin test is positive):

Result: *Normal* *Abnormal* Date of chest x-ray: ___/___/___

**Physician or Nurse Signature:** _____ **Date** _____

**Address:**_____

**Telephone Number**: _____ **Fax Number** _____

**UC Denver Anschutz Medical Campus**
**MENINGOCOCCAL DISEASE INFORMATION FORM**

For all public or nonpublic postsecondary education institutions in Colorado, the state law requires that students complete and return a standard certificate indicating immunizations received by the student be provided with the information below. If the student is under the age of 18 years, the student's parent or guardian must be provided with this information.

- **Meningococcal disease is a serious disease,** caused by a bacteria.
- **Meningococcal disease is a contagious, but a largely preventable, infection of the spinal cord fluid and the fluid that surrounds the brain.** Meningococcal disease can also cause blood infections.
- About 2,600 people get meningococcal disease each year in the United States; 10 to 15 percent of these people die, in spite of treatment with antibiotics. Of those who live, another 10 percent lose their arms or legs, become deaf, have problems with their nervous system, become mentally retarded, or suffer seizures or strokes.
- Anyone can get meningococcal disease, but it is most common in infants less than one year of age and in people with certain medical conditions. **Scientific evidence suggests that college students living in dormitory facilities are at a modestly increased risk of contracting meningococcal disease.**
- **Immunization against meningococcal disease decreases the risk of contracting the disease.** Meningococcal vaccine can prevent four types of meningococcal disease; these include two of the three most common in the United States. Meningococcal vaccine cannot prevent all types of the disease, but it does help to protect many people who might become sick if they do not get the vaccine.
- A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of the meningococcal vaccine causing serious harm, or death, is extremely small. Getting a meningococcal vaccine is much safer than getting the disease.
- More information can be obtained from the Vaccine Information Statement available at www.cdc.gov/nip/publications/VIS. Students and their parents should discuss the risks and benefits of vaccination with their health care providers.

To receive the immunization against meningococcal disease, students should check with the Auraria Immunizations clinic or their own health care provider.

Please indicate below by checking the appropriate box that you either intend to receive the meningococcal vaccine or you do not intend to receive it. Your signature below signifies you have received critical information about meningococcal disease and your intention regarding this vaccination. For students under the age of 18, this document must be signed by a legal parent or guardian. Once you have signed the document below, include this with your packet for submission.

☐ **I have already obtained my meningococcal immunization and I have included the date with my immunization records.**

☐ **I have received information about meningococcal disease and I have decided to obtain a vaccination. I can obtain the vaccine at the Auraria Immunization Clinic or my private physician.**

☐ **I have reviewed the information on meningococcal disease and have decided that I will not obtain a vaccination against meningococcal disease.**

**Date:**_____

**Signature (student or parent/guardian, if student is under the age of 18 years):**_____

**Print Name of Student:**_____

**Date of Birth:** _____

**Student ID Number:** _____