Richard Bland College of WILLIAM & MARY

Certificate of Immunization

Note: This completed form must be mailed, delivered, or faxed to the following:

Office of Residence Life
Richard Bland College
8311 Halifax Road
Petersburg, VA 23805
Phone: 804- 862-6161 Fax: 804-863-1675

Student Name_____
Last First Middle

RBC ID _____ **Date of Birth** _____/_____/_____ **Email** _____

Daytime Phone (_____) _____ **Entering Semester/Year:** ☐ Spring ☐ Fall 20_____

PART I - Must be completed *and* signed by a licensed health professional on the reverse side.

A. Measles, Mumps, Rubella

1. _____ I was born before January 1, 1957. I am considered immune.
   OR

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

   OR all 3 of the 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 rubella vaccine ____/____/____

B. Tetanus- Diphtheria-Pertussis

(Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last 10 years.)

1. Primary series of four doses with DTaP, DTP, DT, or Td:
   #1. ___/ ___/ ___ #2.___/ ___/ ___ #3. ___/ ___/ ___ #4 ___/___/ ___

2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. ……. ___/ ___/___

3. Booster: Td within the last ten years ……___/ ___/ ___

C. Poliomyelitis

1. Primary Childhood Series - date completed: _____/_____/_____ **OR**
2. Positive immune titer _____/_____/_____ OR one dose of IPV - Date _____/_____/_____

D Hepatitis B

1. Immunization (hepatitis B)
   a. Dose #1 ___/ ___/ ___ b. Dose #2 ___/ ___/ ___ c. Dose #3 ___/ ___/ ___
   OR
2. Immunization (Combined Hepatitis A and B vaccine)
   a. Dose #1 ___/ ___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___
   OR
3. Hepatitis B surface antibody Date ___/ ___/ ___
   Results: Reactive _____ None-reactive _____
4. I have received information on the Hepatitis B vaccination and DO NOT wish to be vaccinated
   Signature (Parent or guardian if minor)_____ date: _____

E. Tuberculosis Screening (PPD) - See Part II below (must be completed by health care professional)

F. Meningococcal Vaccine - REQUIRED – OR – SIGN waiver below

All adolescents and teens ages 11-18 should be vaccinated, as should unvaccinated adults who are attending college.

1. **A booster dose will be necessary for those who received their first dose before the age of 16.**
   Menactra ____/_____/_____ OR Menveo ____/_____/_____
   OR
2. Received the information on meningococcal vaccine and DO NOT wish to receive the meningococcal vaccine.

Signature: _____ Date: _____ (Student or if under 18, parent or legal representative)

****

*** PART II - Must be completed**

TUBERCULOSIS SCREENING

The American College Health Association (ACHA) has published guidelines on tuberculosis screening of college and university students. Richard Bland College has adopted those guidelines based on their recommendations. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/corecurr/ .

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 tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Is the student a member of a high-risk group or is the student entering the health professions? (See footnote #1 below) ☐ YES ☐ NO

   If **NO**, stop. **No further evaluation is needed at this time.**

   If **YES**, place tuberculin skin test (Mantoux only; inject 0/1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm). A history of BCG vaccination should not preclude testing of a member of a high-risk group. If PPD is not placed, a chest x-ray is required (see #4 to record x-ray result).

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

   Date Given _____/_____/_____ Date Read _____/_____/_____

   Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")

   Interpretation (based on mm in induration as well as risk factors): ☐ Positive ☐ Negative

4. Chest x-ray (required if tuberculin skin test is positive or if PPD has not been placed for any reason):

   Date of chest x-ray: _____/_____/_____ Result: ☐ Normal ☐ Abnormal

[1]Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemia or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone $\geq$ 15 mg/d for $\geq$ 1 month) or other immunosupressive disorders.

***REQUIRED SIGNATURE BLOCK**

_____

REQUIRED Signature OR Stamp of Licensed Health Professional * ****See Part II above** *** **Date**

_____

Print Name **Address** **Phone**

MEDICAL EXEMPTION: _____Td _____ IPV _____ Measles _____ Rubella _____ Mumps _____ Meningococcal

As specified in Section 23-7.5 of the Code of Virginia, I certify that the administration of the vaccine(s) designated above would be detrimental to this student's health. This contraindication is (circle one) permanent / temporary and is expected to preclude immunization until _____, unless an emergency or epidemic of disease has been declared by the Board of Health.

_____

Signature of Licensed Health Professional Date of Signature

RELIGIOUS EXEMPTION FOR ALL IMMUNIZATIONS

Section 23-7.5 of the Code of Virginia states "Any student shall be exempt from the immunization requirement who objects on the grounds that administration of immunizing agents conflicts with his/her religious tenets or practice, unless an emergency or epidemic of disease has been declared by the Board of Health." Such students must submit a "Certification of Religious Exemption" (form HWC4), which may be obtained by contacting Student Health.

STUDENT HEALTH USE ONLY

Date Processed: _____ Initials: _____ Notes: _____