



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#: _____ 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 _____	<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> US/Canadian students born in 1957 or later If Antibody titer does not indicate immunity, injection series required. You <u>must</u> submit the antibody titer report on lab letterhead from 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 healthcare provider (history of disease reported to provider not sufficient). Provide statement from provider verifying previous infection.	<ul style="list-style-type: none"> <u>SELF/PARENTAL REPORTED HISTORY OF DISEASE NOT 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 series required. You <u>must</u> submit the antibody titer report on lab letterhead from a certified lab with definitive lab values in English.
Tetanus, Diphtheria, Pertussis (Tdap)	Tdap _____ (REQUIRED)	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> All Students who will be 18 or younger on the first day of class. If Antibody titer does not indicate immunity, injection series required. You <u>must</u> submit the antibody titer report on lab letterhead from 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 _____	<ul style="list-style-type: none"> 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.



RECOMMENDED IMMUNIZATION	RECOMMENDED (MM/DD/YYYY)	RECOMMENDED FOR:
Human Papillomavirus⁵	#1 _____ #2 _____ #3 _____	<ul style="list-style-type: none"> 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 _____	<ul style="list-style-type: none"> 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 _____	<ul style="list-style-type: none"> Consider if younger than 23 years of age
Annual Influenza	#1 _____ #2 _____	<ul style="list-style-type: none"> 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.
Tuberculosis (TB)	Complete the Tuberculosis Screening Questionnaire found on page 3.	<ul style="list-style-type: none"> 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: _____	PHYSICIAN OFFICE STAMP
Signature: _____	
Address: _____	
Phone: _____ Date: _____	



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:	>10 mm is positive:	>15 mm is positive if no risk factors
<ul style="list-style-type: none"> • Recent close contact with person with active TB • Abnormal CXR c/w past TB disease • Organ transplant or other immunosuppression HIV/AIDS 	<ul style="list-style-type: none"> • 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 	

SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED

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

PHYSICIAN
 OFFICE STAMP