RADFORD UNIVERSITY

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Health Record Form

The Certificate of Immunization and TB Screening must be completed and submitted to the Office of Undergraduate Admissions **prior to the beginning of your first semester.** Note: students seeking exemption on religious grounds should refer to Part III of this form.

Instructions for Student

- **To submit online:** Visit the secure Medicat website at **https://Radford.medicatconnect.com** and choose Radford University as your college then login using your Radford University username & password.
- **To submit using fax, mail, or email:** Use the appropriate contact information included in the footer section of this page. Include your full name, date of birth, and Student ID with any submitted documentation.
- Additional information, including waiver request forms, can be found at **www.radford.edu/immunization**

Part I: Certificate of Immunization

This MUST be signed by a health care provider (Part IV on second page).

Student Name_____ **Date of Birth**_____ **Student ID#**_____

Required Immunizations	Vaccine Doses Administered				
Hepatitis B ☐Hep. B only *or* ☐Combined Hep. A + B *or* ☐Titers (attached copy of results)	*Check one:* ☐2-dose series ☐3-dose series	1 MM / DD / YY	2 MM / DD / YY	3 MM / DD / YY	• You may choose to submit a waiver for this immunization.
Meningococcal (ACYW–135) Must have at least one vaccine after the age of 16.	1 MM / DD / YY	2 MM / DD / YY	• You may choose to submit a waiver for this immunization.		
Measles, Mumps, Rubella (MMR) *Students born before 1957 are not required to have a second MMR vaccination.*	1 MM / DD / YY	2 MM / DD / YY	• You may choose to submit titers indicating positive immunity in lieu of this section.		
Tetanus, Diphtheria ☐Tetanus Diphtheria (Td) *or* ☐Tetanus Diphtheria Acellular Pertussis (Tdap)	Date Completed MM / DD / YY	• Must have been given within the last ten years.			
Poliomyelitis (OPV or IPV)	Date Series Completed MM / DD / YY				

Recommended Immunizations	Vaccine Doses Administered			
COVID-19 ☐ Johnson & Johnson ☐ Moderna ☐ Pfizer ☐ Other (specify)_____	1 MM / DD / YY	2 MM / DD / YY	Booster MM / DD / YY	**Booster manufacturer:** ☐ Johnson & Johnson ☐ Moderna ☐ Pfizer
Serogroup B Meningococcal Vaccine ☐ 1 Dose ☐ 2 Dose	1 MM / DD / YY	2 MM / DD / YY	3 MM / DD / YY	☐ Bexsero ☐ Trumenbra
HPV, Quadrivalent or Bivalent Age 26 Or Under	1 MM / DD / YY	2 MM / DD / YY	3 MM / DD / YY	
Tetanus Diphtheria Acellular Pertussis (Tdap) *Tetanus Diphtheria (Td) is required (see above)*	Date Completed MM / DD / YY	• Must have been given within the last ten years.		
Hepatitis A	1 MM / DD / YY	2 MM / DD / YY		
Combined Hepatitis A + B Vaccine Hepatitis B is required (see above)	1 MM / DD / YY	2 MM / DD / YY		
Pneumococcal Vaccine High-risk individuals	1 MM / DD / YY			
Varicella Strongly recommended; two doses for individuals with no history of disease.	1 MM / DD / YY	2 MM / DD / YY	3 MM / DD / YY	• You may choose to submit lab results for titers indicating immunity.
Influenza (Flu) Vaccine	1 MM / DD / YY			

Student Name _____ **Date of Birth** _____ **Student ID#** _____

Part II: Tuberculosis Screening

MUST be completed within six months prior to enrollment start date.

1. Does the student have signs or symptoms of active TB disease? ***If NO***, proceed to question 2. ***If YES***, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, QFT-TB test, chest x-ray and sputum evaluation as indicated. Documentation required that all tests are negative or that treatment is effective and student free of communicable disease.	☐NO ☐YES
2. Is the student a member of a high-risk group? 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, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone > 15 mg/d for > 1 month_) or other immunosuppressive disorders. ***If NO***, continue to question 3. ***If YES***, perform TST or obtain QFT (preferred). If positive TST, obtain QFT.	☐NO ☐YES
3. Was the student BORN in, or have they LIVED in or TRAVELED to countries *OTHER* than those listed below? *Albania, American Samoa, Andorra, Antigua and Barbuda, Aruba, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Curacao, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Monaco, Montenegro, Montserrat, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tokelau, Tonga, Trinidad & Tobago, United Arab Emirates, United Kingdom, United States Virgin Islands, West Bank and Gaza Strip, United States of America.* ***If NO***, no further action is needed. ***If YES***, perform TST or obtain QFT-TB (preferred). If positive TST, obtain QFT-TB.	☐NO ☐YES

TST	Date Given _____ MM / DD / YY	Date Read _____ MM / DD / YY	Result: _____ mm (transverse induration)
QFT-TB	Date Obtained _____ MM / DD / YY	Result: ☐Positive (if positive QFT, see interpretation below) ☐Negative	
Interpretation (based on mmm and induration and risk factors)	☐Positive ☐Negative		
If positive TST interpretation, ***obtain QFT***	Date Obtained _____ MM / DD / YY	Result: ☐Positive ☐Negative	
If positive QFT result, ***obtain CXR***	Date Obtained _____ MM / DD / YY	Result: ☐Normal ☐Abnormal	• If abnormal, return to Question 1, answer yes. • If normal, initiate INH.
If normal CXR result, ***initiate INH***	Date Initiated _____ MM / DD / YY	Date Completed _____ MM / DD / YY	

Part III: Exemption Request

Medical Exemption (does not apply to Tuberculosis screening/testing)

☐ Tdap ☐ Td ☐ Hepititis B ☐ Measles ☐ Rubella ☐ Mumps ☐ Meningococcal ☐ Poliomyelities

As specified in the Code of Virginia, I certify that administration of the above designated vaccine(s) would be detrimental to this student's health.

The vaccine(s) is (are) specifically contraindicated because _____

This contraindication is ☐Permanent ☐Temporary and expected to preclude immunization until _____

Healthcare Provider Name _____ **Telephone** _____

Healthcare Provider Signature _____ **Date** _____

Religious Exemption

Any student who objects on the grounds that administration of immunizing agents conflicts with his religious tenets or practices shall be exempt from the immunization requirements unless an emergency of epidemic disease has been declared by the Board of Health. An affidavit of religious exemption must be submitted on a Certificate of Religious Exemption (Form CRE-1) found at www.radford.edu/immunization.

Self Exemption (Hepatitis B and/or Meningococcal ONLY)

Please review full vaccine information at www.radford.edu/immunization before signing.

I have read and reviewed information on the risk associated with Hepatitis B disease as well as availability and effectiveness of any vaccine against Hepatitis B and I choose not to be vaccinated against Hepatitis B disease.

_____ Signature _____ Date

I have read and reviewed information on the risk associated with meningoccoccal disease as well as availability and effectiveness of any vaccine against meningoccoccal and I choose not to be vaccinated against meningoccoccal.

_____ Signature _____ Date

Part IV: Healthcare Provider Signature

(Must be MD, DO, NO, or PA)

Printed Name _____ **Telephone** _____

Address _____

Signature _____ **Date** _____