Georgia Tech Stamps Health Services
Campus Services

MEDICAL ENTRANCE FORM (REQUIRED)

UNDER 18 YEARS OF AGE ONLY

(If over 18, continue to page 2)

Please upload completed form at www.immunizations.health.gatech.edu

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS

Semester Beginning: _____

GT ID#: _____ Cell Phone #: _____ Email:_____

Name (Last, First, Middle) _____

Address: _____ City:_____ State: _____ Country: _____

Zip Code: _____ Birth Date: _____

AUTHORIZATION TO TREAT

I hereby authorize the physicians, physician assistants and nurse practitioners of Stamps Health Services, including those at area hospitals, to perform diagnostic, preventative, and treatment procedures which in their judgment may be necessary while she/he attends Georgia Tech. I waive all claim to prior notification. I understand that every reasonable effort will be made to notify me in the event of a major illness or injury, or if the Stamps Health Services physician feels it is necessary.

Signature of parent/guardian: _____ **Date:** _____

Print Name: _____ **Relationship:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Daytime phone: _____ Evening phone: _____ Email: _____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Daytime phone: _____ Evening phone: _____ Email: _____

Georgia Tech Stamps Health Services Campus Services

CERTIFICATE OF REQUIRED IMMUNIZATIONS

Please upload completed forms at www.immunizations.health.gatech.edu

Please read ALL instructions below. Your records MUST meet these criteria to satisfy the requirements.

Semester Beginning: _____ Birth Date: _____ **Country of Birth:** _____

GT ID#: _____ Cell Phone #: _____ Email: _____

Name (Last, First, Middle) _____

Address: _____ City: _____ State: _____ Zip Code: _____ Country: _____

Vaccine	Injection 1 Date MM/DD/YYYY	Injection 2 Date MM/DD/YYYY	Injection 3 Date MM/DD/YYYY	**OR**	Date of Positive Lab/ Serologic Evidence(titer)[6]
MMR (Measles, Mumps, Rubella)[1] **or** Measles[1] + Mumps[1] + Rubella[1]	/ /	/ /			
	/ /	/ /			/ /
	/ /	/ /			/ /
	/ /				/ /
Varicella[2] History of Disease Not Accepted	/ /	/ /			/ /
Tetanus-Diphtheria-Pertussis (Whooping Cough)[3]	/ / Tdap (required) Age 10 or above	/ / Booster Td or Tdap (Circle One)			
Hepatitis B[4] 3 dose Hep B **or** 2 dose Heplisav **or** Twinrix (Circle One)	/ /	/ /	/ /		/ /
Meningococcal ACWY[5] (Menactra or Menveo)	/ /	/ /			
Tuberculosis Screening (must be done within 6 months of the start of class)	**U.S./Canadian Born Students** - Complete Page 4 (TB Assessment, required) and Page 6 (Skin Test, if TB Assessment indicates at risk) **International Born Students** - Complete a QuantiFERON blood test (submit official lab report). If QuantiFERON test is positive Chest x-ray performed in the US is required. QuantiFERON must be performed on the same day any live vaccines are administered **or** at least 28 days after any live vaccines are administered.				

1-US/Canadian born students born in 1957 or later; All foreign born students regardless of year born; First dose must be after first birthday.

2-US/Canadian born students born in 1980 or later; All foreign born students regardless of year born; First dose must be after first birthday. History of disease not accepted.

3-**One dose of Tdap after 10th birthday is required for all students**; Td booster needed only if > 10 years since last Tdap or Td.

4-Hepatitis B vaccine or Hepatitis A-Hepatitis B (Twinrix) vaccine accepted. 0, 1, and 6 month schedule preferred.

5-**Vaccine required for all students under age 22. If vaccine given before 16th birthday, a booster dose on or after the 16th birthday is required.** This is not the same vaccine as the Meningococcal B vaccine (see recommended vaccines page).

6-Upload antibody titer reports; must be on lab letterhead or printed from an electronic medical record; must be in English and include definitive lab values with reference values. Lab/serologic evidence indicating immunity may be used in lieu of injections to verify immunity if immunization records incomplete.

SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED

Name: _____

Signature: _____

Phone: _____ **Date:** _____

PHYSICAN OFFICE STAMP

Georgia Tech Stamps Health Services
Campus Services

CERTIFICATE OF RECOMMENDED AND TRAVEL IMMUNIZATIONS

These immunizations are not required but recommended in some situations

Please add COVID-19 vaccination info if you have received this vaccine

Please upload completed form at www.immunizations.health.gatech.edu

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS

Semester Beginning: _____ **Country of Birth:** _____

GT ID#: _____ Cell Phone #: _____ Email:_____

Name (Last, First, Middle) _____

Address: _____ City:_____ State: _____ Country: _____

Zip Code: _____ **Birth Date**: _____

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY
COVID-19 ***Pfizer***			
Moderna			
Johnson & Johnson			
Other: Brand Name_____			
HPV 4 or 9 (circle one)			
Meningococcal B *Not Menactra or Menveo*			
Bexsero			
Trumenba			
Hepatitis A			
Pneumonia Pneumovax Or Prevnar (Circle One)			
Yellow Fever			
Typhoid Oral or Injection (Circle One)			
Polio Adult booster			
Japanese Encephalitis			
Rabies			
Annual Influenza			

CERTIFICATION OF HEALTHCARE PROVIDER

Name: _____

Signature: _____

Phone: _____ **Date:** _____

Physician Office Stamp

Effective Date of Revision 2/17/2021

Georgia Tech Stamps Health Services Campus Services

TUBERCULOSIS (TB) ASSESSMENT FORM (REQUIRED)
US/CANADIAN BORN STUDENTS ONLY

Please upload completed form at www.immunizations.health.gatech.edu.

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

All international born students must receive a QuantiFERON test.

Semester Beginning: _____ Country of Birth: _____

GT ID#: _____ Birth Date: _____ Cell Phone #: _____ Email: _____

Name (Last, First, Middle) _____

Address: _____ City:_____ State: _____ Zip Code: _____ Country: _____

INSTRUCTIONS TO PROVIDER

TB assessment must be done within six (6) months prior to start of classes**.** PLEASE NOTE: TB skin tests, TB assessment and chest x-rays conducted outside of the United States of America or Canada will NOT be accepted under any circumstances. **If at risk, a tuberculin skin test or tuberculosis blood test (Quantiferon or T-Spot accepted) must be completed within 6 months prior to the first day of class.**

History:

1. Have you ever had a positive test for tuberculosis (blood or skin test)? ☐ **No** ☐ **Yes** If so, date of test: _____
2. Did you take medication(s) for the positive test**?** ☐ **No** ☐ **Yes**
   If yes, please list dates of treatment and medication taken: _____
3. Have your ever received a BCG (Bacillus Calmette–Guérin) vaccine? ☐ **No** ☐ **Yes** If yes, QuantiFERON test recommended.

If student has had a positive tuberculosis test in the past, the student will need a chest x-ray done no more than 6 months prior to the first day of class. An official report of the chest x-ray results will need to be uploaded. Chest x-rays performed outside of the United States or Canada will NOT be accepted.

Symptom Risk: Do you currently have any of the following symptoms?				**Symptom risk present?** (any question to the left answered yes) ☐ No ☐ Yes
3 weeks or more of Persistent Cough?	☐ No ☐ Yes	Unexplained weight loss?	☐ No ☐ Yes	
Persistent Fever or Chills?	☐ No ☐ Yes	Persistent Night Sweats	☐ No ☐ Yes	
Loss of Appetite?	☐ No ☐ Yes	Coughing up blood?	☐ No ☐ Yes	
Exposure Risk: Have you lived, worked, or volunteered in the following types of facilities?				**Exposure risk present?** (any question to the left answered yes) ☐ No ☐ Yes
Hospital?	☐ No ☐ Yes	Prison?	☐ No ☐ Yes	
Homeless Shelter	☐ No ☐ Yes	Nursing Home?	☐ No ☐ Yes	
Long Term Care Facility?	☐ No ☐ Yes	Residential Facility for patients with AIDS?	☐ No ☐ Yes	
Rehabilitation Facility?	☐ No ☐ Yes	Had contact with a person known to have TB?	☐ No ☐ Yes	
Travel Risks:				**Travel risk present?** (Yes to the question on the left) ☐ No ☐ Yes
Have you had frequent or prolonged visits to one or more of the countries or territories listed below with a moderate or high prevalence of TB disease?			☐ No ☐ Yes	
Countries traveled or lived in:				

If the student has any one of the risks in the right hand column above marked YES they will need a TB skin test (PPD) or a QuantiFERON test done.

CERTIFICATION OF HEALTHCARE PROVIDER AND DATE REQUIRED

Is this student at risk for TB Exposure? (One or more risk(s) in the right hand column of the table above present)

☐ **YES** (complete TB Skin Testing Form) ☐ **NO**

Provider Name: _____ Date: _____Phone # _____

Signature: _____

Georgia Tech Stamps Health Services Campus Services

TUBERCULOSIS (TB) ASSESSMENT FORM (REQUIRED)
US/CANADIAN BORN STUDENTS ONLY

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Countries with moderate or high risk of TB:

Afghanistan	Congo-Democratic Republic	Korea-Republic of	Pakistan	Tuvalu
Algeria	Cote d'Ivoire	Kuwait	Palau	Uganda
Angola	Djibouti	Kyrgyzstan	Panama	Ukraine
Anguilla	Dominican Republic	Lao People's Democratic Republic	Papua New Guinea	Uruguay
Argentina	Ecuador	Latvia	Paraguay	Uzbekistan
Armenia	El Salvador	Lesotho	Peru	Vanuatu
Azerbaijan	Equatorial Guinea	Liberia	Philippines	Venezuela (Bolivarian Republic of)
Bangladesh	Eritrea	Libya	Portugal	Viet Nam
Belarus	Eswatini	Lithuania	Qatar	Yemen
Belize	Ethiopia	Madagascar	Romania	Zambia
Benin	Fiji	Malawi	Russian Federation	Zimbabwe
Bhutan	French Polynesia	Malaysia	Rwanda	
Bolivia	Gabon	Maldives	Sao Tome and Principe	
Bosnia and Herzegovina	Gambia	Mali	Senegal	
Botswana	Georgia	Marshall Islands	Sierra Leone	
Brazil	Ghana	Mauritania	Singapore	
Brunei Darussalam	Greenland	Mexico	Solomon Islands	
Bulgaria	Guam	Micronesia (Federated States of)	Somalia	
Burkina Faso	Guatemala	Moldova-Republic of	South Africa	
Burundi	Guinea	Mongolia	South Sudan	
Cabo Verde	Guinea-Bissau	Morocco	Sri Lanka	
Cambodia	Guyana	Mozambique	Sudan	
Cameroon	Haiti	Myanmar	Suriname	
Central African Republic	Honduras	Namibia	Tajikistan	
Chad	India	Nauru	Tanzania UR	
China	Indonesia	Nepal	Thailand	
China, Hong Kong SAR	Iraq	Nicaragua	Timor-Leste	
China, Macao SAR	Kazakhstan	Niger	Togo	
Colombia	Kenya	Nigeria	Tokelau	
Comoros	Kiribati	Niue	Tunisia	
Congo	Korea-DPR	Northern Mariana Islands	Turkmenistan	

Georgia Tech Stamps Health Services Campus Services

TUBERCULOSIS (TB) SKIN TESTING FORM
(US/CANADIAN STUDENTS ONLY)

**RISK DETERMINED BY HEALTHCARE PROVIDER USING TB ASSESSMENT FORM **

Please upload completed form at www.immunizations.health.gatech.edu.

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

Semester Beginning: _____ Country of Birth: _____

GT ID#: _____ Cell Phone #: _____ Email:_____

Name (Last, First, Middle) _____

Address: _____ City:_____ State: _____ Country: _____

Zip Code: _____ Birth Date: _____

TUBERCULIN SKIN TEST *(Only accepted if completed in the US/Canada)* TUBERCULIN SKIN TEST MUST BE COMPLETED WITHIN 6 MONTHS OF THE FIRST DAY OF CLASS.

Date placed _____ L / R (MMDDYY)

Placed By: _____

Lot #: _____ Exp Date: _____ (MMDDYY)

Date read_____ (must be within 48 to72 hours) (MMDDYY)

Read By: _____

Result _____mm (record actual mm of induration, transverse diameter. If no induration, record as "0 mm")

Declined due to QuantiFERON test completed: Date:_____ (attach the official lab report)

FINAL INTERPRETATION- Based on Criteria for Tuberculin Positivity below, by Risk Group ☐ **POSITIVE** ☐ **NEGATIVE**

Reaction > 5 mm of Induration	Reaction > 10mm of Induration	Reaction > 15mm of Induration
• Human immunodeficiency virus (HIV)-positive persons	• Recent immigrants to the U.S. (within the last 5 years) from high prevalence countries	• Person with no risk factors for TB
• Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of ≥ 15 mg/d of prednisone for 1 month or more	• Persons with silicosis, diabetes, chronic renal failure, leukemias and lymphomas, carcinoma of the head, neck and lung, weight loss of ≥10% of ideal body weight, gastrectomy, and jejunoileal bypass	• Persons who are otherwise at low risk and are tested at the start of employment, a reaction of ≥15 mm is considered positive
• Fibrous changes on chest x-ray consistent with prior TB	• Residents and employees of the high risk congregate settings.	
• Recent contacts of infectious TB case	• Mycobacterial laboratory personnel	
	• Injecting drug users	
	• Children less than 5 years of age or infants, children, and adolescents exposed to adults at high-risk	
	• Recent conversion (increase of ≥ 10 mm of induration within the past 2 years	

Chest X-RAY (Required if history of positive skin test, **Chest x-ray must be completed in the US/ Canada ONLY.** Chest x-ray must be performed after the date of the positive skin testing. XRAYS MUST BE COMPLETED WITHIN 6 MONTHS OF THE FIRST DAY OF CLASS. **Upload a copy of the chest x-ray report signed by the doctor.**

Date of chest x-ray _____ (MMDDYY) Date of Positive PPD: _____ (MMDYY) **Result:** ☐ **NORMAL** ☐ **ABNORMAL**

Treatment for latent TB

INH given? ☐ YES ☐ NO Rifampin ☐ YES ☐ NO

Other Treatment:_____

Duration of Treatment: From _____ (MMDDYY) to_____ (MMDDYY)

SIGNATURE OF HEALTHCARE PROVIDER AND DATE REQUIRED

Provider Name: _____

Signature: _____

Phone: _____ Date: _____

PHYSICAN OFFICE STAMP