THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
EDUCATION • RESEARCH • HEALTHCARE

STUDENT AND EMPLOYEE HEALTH

IMMUNIZATION RECORD

Record of vaccination should be documented on a Mississippi Certificate of Immunization Compliance, Form 121E or the UMMC Immunization Record form. Immunization history must be completed by a licensed healthcare provider: a physician, a licensed Nurse Practitioner, a Licensed Nurse or a Public Health Officer.

PART I – TO BE COMPLETED BY YOU

Name _____ _____
First Name Middle Name

_____
Last Name

Address _____
Street City State Zip

Anticipated Start____/_____ Date of Birth ____/____/_____ Country and State/Province of Birth _____
M Y M D Y

Passport or Driver's License or State ID card# _____

Status: Employee _____ Observer _____ Volunteer _____ Student _____ Professional _____ Other (List) _____

IF a student, state the program in which you are enrolling_____

PART II – COMPLETE AND HAVE FORM SIGNED BY YOUR PERSONAL HEALTH CARE PROVIDER.

All information must be in English and legible.

A. MMR (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for those born after 1956 or titers.)

1. Dose 1 given at age 12 months or later. #1 ____/____/_____ OR Date of titer ____/_____/_____
   M D Y Rubeola titer: positive Yes_____ No_____
2. Dose 2 given at least 28 days after first dose. #2 ____/____/_____ Rubella titer: positive Yes_____ No_____
   M D Y

B. POLIO

(Primary series, doses at least 28 days apart. Three primary series are acceptable.)

1. OPV alone (oral Sabin three doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____
   M D Y M D Y M D Y
2. IPV/OPV sequential: IPV #1 ____/____/_____ IPV #2 ____/____/_____ OPV #3 ____/____/_____ OPV #4 ____/____/_____
   M D Y M D Y M D Y M D Y
3. IPV alone (injected Salk four doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ #4 ____/____/_____
   M D Y M D Y M D Y M D Y

C. VARICELLA

(A positive varicella antibody, or two doses of vaccine meets the requirement.)

1. Varicella antibody ____/____/_____ Result: Reactive _____ Non-reactive _____
   M D Y
2. Immunization
   a. Dose #1 . .....#1 ____/____/_____
   M D Y
   b. Dose #2 given at least 12 weeks after first dose ages 1-12 years. .....#2 ____/____/_____
   and at least 4 weeks after first dose if age 13 years or older. M D Y

Name:_____**Program**_____

D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___

   Date of last dose in series: ___/___/_____ (Within past 10 years.)
   M D Y

2. Date of most recent booster dose: ___/___/_____ Must have one Tdap booster within past 10 years
   M D Y

   Type of booster: Td _____ Tdap _____ (*Tdap booster needed unless contraindicated).*

E. INFLUENZA (Needed October – March: Flu Season)

Date of last dose: ___/___/_____
M D Y

F. HEPATITIS B

(Three doses of vaccine or a positive hepatitis B surface antibody meets the requirement).

1. Immunization (hepatitis B)

   a. Dose #1 ___/___/_____ b. Dose #2 ___/___/_____ c. Dose #3 ___/___/_____
   M D Y M D Y M D Y

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ___/___/_____ b. Dose #2 ___/___/_____ c. Dose #3 ___/___/_____
   M D Y M D Y M D Y

3. Hepatitis B surface antibody Date ___/___/_____ Result: Reactive _____ Non-reactive _____
   M D Y

G. MENINGOCOCCAL QUADRIVALENT (OPTIONAL)

(A, C, Y, W-135) One or 2 doses for all students with potential for exposure – revaccinate every 5 years if increased risk continues.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
   M D Y M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

   Date ____/____/_____
   M D Y

CERTIFICATION: TO BE COMPLETED BY YOUR PERSONAL HEALTHCARE PROVIDER

Name & Title_____ Signature _____Date_____

Print Address _____

Provider Phone (_____)_____

Provider Email Address _____

Healthcare Providers having questions or needing other assistance may contact:
Noruwa Agho OR Tiffanie Robinson, LPN
Telephone: 601-815-3410 OR 601-984-4080
Email: studenthealth@umc.edu

University of Mississippi Medical Center - 2500 N. State Street - Jackson, MS 39216 USA

Name: _____ Program in which you are enrolling_____

TUBERCULOSIS (TB) RISK ASSESSMENT *(to be completed by your personal health care provider)*

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes _____ No _____**

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes _____ No _____**

Country of birth_____

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1. TB Symptom Check

Does the person have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____

If No, proceed to 2 or 3

If yes, check below:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats ❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST). Most have a 2-Step TST completed within 90 days of beginning of semester.

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

** The significance of the travel exposure should be discussed with your personal health care provider or public health officer and evaluated.*

3. Interferon Gamma Release Assay (IGRA) preferred if you have received BCG vaccination

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Name: _____Program:_____

TB RISK ASSESSMENT (continued)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Management of Positive TST or IGRA

All with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, those in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

••Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

_____ Person agrees to receive treatment

_____ Person declines treatment at this time

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