COLGATE UNIVERSITY
Student Health Services
315-228-7750

IMMUNIZATION RECORD

13 Oak Drive
Hamilton, NY 13346-1398
studenthealth@colgate.edu

Completion of this form is required prior to enrollment. Colgate University will also accept a copy of your immunization record attached to this form.

Name ____
Last First M.I.

Date of Birth (Month / Day / Year)____/____/____ Anticipated Year of Graduation from Colgate __________

New York State Public Health Law requires that all students born after December 31, 1956, be adequately immunized. ***You are legally required to provide this information and to get the necessary immunizations, or you will be DENIED enrollment.*** If you qualify for a medical or religious exemption, please **complete Part III.**

INCLUDE MONTH DATE AND YEAR OF ALL VACCINES

Part I - **Meningococcal Vaccine** (**Must complete category 1A and category 1B**)

As required by NYS Public Health Law, I have read or had explained to me, the information enclosed with this form about meningococcal disease.

After choosing one of the following under section A, the **student or parent/guardian (if student under age 18) must sign below.***

1A.____I have had the Quadrivalent Meningococcal Conjugate Vaccine (ex:**Menactra/Menveo**): #1 [ ] AND #2 (given on or after 16th Birthday) [ ]

OR

____ I decline to receive the vaccine at this time and understand the risks.

**Student or Parent/Guardian (if student under age 18) Signature* Date

1B.____Meningococcal B Vaccine (Please Circle Brand Name): **Bexsero OR Trumenba)** – discuss with your primary care provider. **Please indicate dates if received.**

#1 [ ] #2 [ ] #3 (If applicable) [ ]

PART II — TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR.

If convenient, you may attach a ***signed*** copy of your immunization records, which must include all previous and recent shots.

A. **M.M.R.** (Measles, Mumps, Rubella) (Two doses required.)
1. Dose 1 given at age 12-15 months or later. .... [ ]
AND
2. Dose 2 given at age 4-6 years or later, and at least one month after the first dose. .... [ ]

B. **Tetanus-Diphtheria-Pertussis** (Primary series with DtaP or DTP and booster in the last ten years meets the requirement.)
1. Primary series of at least four doses with DtaP or DTP: #1 [ ] #2 [ ] #3 [ ] #4 [ ] #5 [ ]
AND
2. Tetanus-Diphtheria-Acellular Pertussis (Tdap) booster (one dose needed within past 10 years).......... [ ]
3. Please indicate type and date of any other tetanus vaccine: Type:____________________ [ ]

C. **Polio** (Primary series in childhood meets requirement.) #1 [ ] #2 [ ] #3 [ ] #4 [ ]

D. **Varicella** (Either a history of **chickenpox**, a positive Varicella antibody, or two doses of vaccine given at least one month apart, meets the requirement.)
1. Immunization: #1 [ ] #2 (given at least one month after first dose) [ ]
OR
2. History of the Varicella disease: (include date) [ ]
OR
3. Varicella blood work: Non-reactive [ ] **OR** Reactive [ ] (include date) [ ]

E. **Hepatitis B** (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)
1. Immunization: #1 [ ] #2 [ ] #3 [ ]
OR
2. Hepatitis B Surface antibody: Non-reactive [ ] **OR** Reactive [ ] (include date) [ ]

F. **Quadrivalent Human Papillomavirus Vaccine** State month, day and year.
1. HPV-**4** #1 [ ] #2 [ ] #3 [ ]
OR
2. HPV-**9** #1 [ ] #2 [ ] #3 [ ]

G. **Hepatitis A** (Two doses, given at least 6 months apart, for those who travel to parts of the USA or other countries with high rates of Hepatitis A.)
State month, day and year. #1 [ ] #2 [ ]

H. **Other** Other Immunizations (such as Pneumococcal, etc.): ____

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Name (please print):____

Signature:____ Title:______________________Date: ______________

Address:____ Phone:______________________Fax: ______________

PART III - STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS WILL BE SUBJECT TO EXCLUSION FROM SCHOOL AND QUARANTINE.

MEDICAL EXEMPTION

The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

____ ____________
Signature of Physician Date

RELIGIOUS EXEMPTION

Parent or guardian of the above named person or the person himself/herself adheres to a religious belief opposed to immunizations.

____
Student's Signature (parent/guardian if under 18) Date

Colgate University Student Health Service
Required Tuberculosis (TB) Screening Questionnaire

I. To be completed by incoming students.

Student Name: ____ DOB_____/_____/_____
(PLEASE PRINT) Last Name First Name M.I.

A) Have you had a previous positive TB Skin Test or IGRA Blood Test?

□ No **If No, Proceed and answer the 5 questions in Part B.**

□ Yes **If Yes, complete Part B below AND complete Required TB Screening form on the next page**

B) 1. Have you ever had close contact with persons known or suspected to have active TB disease? □ No □ Yes

2. Were you born outside the USA? □ No □ Yes (If yes, where?____________________________________)

3. Have you had frequent or prolonged visits* (more than 4 weeks) to one or more of the countries listed with a high prevalence of TB disease? (If yes, **CHECK** the countries in the box below) □ No □ Yes

4. Have you been a volunteer or worker in a health care facility (e.g., hospital, nursing home, or health clinic)? □ No □ Yes

5. Have you been a resident, employee, or volunteer at high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? □ No □ Yes

If the answer to all of the above 5 questions is NO and you were not born or traveled to a country listed above, no further testing or action is required and you do not need to have your Health Care Provider complete the next page.

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Student Signature____ Date _______________ SIGN HERE

*The countries listed in the box below have a high incidence of active TB disease.

If you answered is YES to any of the above 5 questions, Colgate University requires that your **Health Care Provider must complete the Required TB Screening form on the next page**.

Afghanistan Algeria Angola Argentina Armenia Azerbaijan Bahrain Bangladesh Belarus Belize Benin Bhutan Bolivia (Plurinational State of) Bosnia and Herzegovina Botswana Brazil Brunei Darussalam Bulgaria Burkina Faso Burundi Cambodia Cameroon Cape Verde Central African Republic	Chad China Colombia Comoros Congo Côte d'Ivoire Croatia Democratic People's Republic of Korea Democratic Republic of the Congo Djibouti Dominican Republic Ecuador El Salvador Equatorial Guinea Eritrea Estonia Ethiopia Fiji Gabon Gambia Georgia	Ghana Guam Guatemala Guinea Guinea-Bissau Guyana Haiti Honduras India Indonesia Iraq Japan Kazakhstan Kenya Kiribati Kuwait Kyrgyzstan Lao People's Democratic Republic Latvia Lesotho Liberia Libyan Arab Jamahiriya Lithuania	Madagascar Malawi Malaysia Maldives Mali Marshall Islands Mauritania Mauritius (Federated States of) Micronesia Mongolia Morocco Mozambique Myanmar Namibia Nepal Nicaragua Niger Nigeria Pakistan Palau Panama Papua New Guinea Paraguay Peru Philippines	Poland Portugal Qatar Republic of Korea Republic of Moldova Romania Russian Federation Rwanda Saint Vincent and the Grenadines Sao Tome and Principe Senegal Seychelles Sierra Leone Singapore Solomon Islands Somalia South Africa Sri Lanka Sudan Suriname Swaziland Syrian Arab Republic	Tajikistan Thailand The former Yugoslav Republic of Macedonia Timor-Leste Togo Tunisia Turkey Turkmenistan Tuvalu Uganda Ukraine United Republic of Tanzania Uruguay Uzbekistan Vanuatu Bolivarian Republic of Venezuela Viet Nam Yemen Zambia Zimbabwe

Colgate University Student Health Service
Required Tuberculosis (TB) Screening

TO BE COMPLETED ONLY IF STUDENT ANSWERED YES TO ANY OF THE 5 QUESTIONS IN SECTION I, PART A or B.

Student Name:_______________________________________ _______________ DOB _____/_____/_____
(PLEASE PRINT) Last Name First Name M.I.

Medical practitioner:

- Screening must be done within 6 months of the first day of classes.
- A student who has any positive risk factors must be tested for TB infection if there is no written documentation of a previous positive tuberculin skin test (TST) or Interferon-gamma release assay (IGRA) (e.g. T-Spot, Quantiferon Gold).
- Previous BCG Immunization does not change TB screening requirements.

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☐ No

If no, proceed to 2 and/or 3.

If yes, check symptom(s) below and proceed with an additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

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

2. Tuberculin Skin Test (TST)** https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm

(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:_____/____/_____

Result:_________mm of induration **Interpretation: positive __________negative_____

AND/OR

3. Interferon Gamma Release Assay (IGRA)

Date Obtained:____/____/____(QFT-GIT, T-Spot)

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

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

Date Obtained:____/____/____

Result: normal_____ abnormal ____

5. Please indicate any treatment given for positive TB testing: ____

____

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Name (please print): ______________________________________

Signature:____Title:_____________________ Date: _______________

Address:____Phone:_________________Fax: ________________