STUDENT HEALTH SERVICES
13 Oak Drive
Hamilton, NY 13346
Phone: 315-228-7750 Fax: 315-228-6823
studentheatlh@colgate.edu

2021-2022 IMMUNIZATION FORM for INCOMING STUDENTS

Incoming students must complete the immunization requirements before arriving on campus.

PLEASE NOTE: IF YOU SUBMIT THIS FORM AS YOUR PROOF OF IMMUNIZATION HISTORY, IT MUST BE SIGNED OR STAMPED BY YOUR MEDICAL PROVIDER.

STUDENT HEALTH SERVICES WILL ACCEPT A SIGNED COPY OF YOUR IMMUNIZATION RECORD INSTEAD OF THIS FORM.

LAST NAME:	FIRST NAME , MIDDLE INITIAL:	PREFERRED FIRST NAME:	DATE OF BIRTH *(MM/DD/YYYY)*:
COLGATE EMAIL ADDRESS:		Anticipated Year of Graduation from Colgate	

REQUIRED

MMR 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW. ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1	DOSE #2		
OR				
Measles (Rubeola) 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1	DOSE #2	***OR***	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Mumps 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1	DOSE #2	***OR***	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Rubella (German Measles) 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1		***OR***	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Hepatitis B 3 DOSES REQUIRED	DOSE #1	DOSE #2	DOSE #3 ***OR***	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Tetanus-Diphtheria-Pertussis DOSES:		**Circle One: Tdap or Td** (WITHIN THE LAST 10 YEARS)		LAST TDAP BOOSTER DATE
Varicella (Chicken Pox) 2 DOSES REQUIRED OR DATE OF ILLNESS	ILLNESS DATE ***OR*** DOSE #1	DOSE #2	***OR***	*OR* LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
COVID LIST VACCINE NAME:	DOSE #1	DOSE #2 if applicable		DOSE #3/Booster
Meningococcal ACWY DOSE SINCE AGE 16 AND WITHIN THE PAST 5 YEARS		LAST DOSE:		LIST VACCINE NAME OR **SEROGROUPS COVERED:**_____
OR				

As required by NYS Public Health Law, I have read or had explained to me, the information about meningococcal disease and I decline to receive the vaccine at this time and understand the risks. Student or Parent/Guardian (if student under age 18). Signature_____ Date_____

RECOMMENDED

THE VACCINES LISTED BELOW ARE RECOMMENDED BASED ON AGE OR DISEASE CRITERIA. PLEASE CHECK WITH YOUR CLINICIAN.

Hepatitis A	DOSE #1	DOSE #2	***OR***	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
HPV (Human Papillomavirus) ☐ HPV4 or ☐ HPV9	DOSE #1	DOSE #2	DOSE #3	
Meningococcal B (Bexsero/Trumenba) LIST VACCINE NAME:	DOSE #1	DOSE #2	DOSE #3 if applicable	

ADDITIONAL VACCINES

INFLUENZA VACCINE RECOMMENDED ANNUALLY

Polio	DOSE #1	DOSE #2	DOSE #3	DOSE #4
Other (pneumococcal, typhoid, etc.) LIST VACCINE NAMES AND DATES				

PROVIDER INFORMATION

SIGNING PROVIDER IS VERIFYING ALL DATES ABOVE ARE ACCURATE

Provider Name (Please Print)	**Title**	**Clinical or Organization Stamp**
Address	**Phone**	
Signature	**Date**	

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TUBERCULOSIS (TB) SCREENING for the 2021-2022 ACADEMIC YEAR

Complete sections A and B. If you answer yes to any questions, please have your health care provider complete section C. Form must be signed and returned to above address by July 13, 2021.

Name (please print): _____ Colgate ID#: _____
Last First MI

Country of Birth: _____ Year arrived in US: _____

SECTION A: History of Tuberculosis (TB)?

1. Have you ever been sick with tuberculosis? **YES** ☐ NO☐

2. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT? **YES** ☐ **NO** ☐

AND

SECTION B: At Risk for Tuberculosis (TB)?

1. Were you born in, or have you lived, worked or visited for more than one month a country with High TB Burden: **YES** ☐**NO** ☐
If unsure- review list found at: https://www.vdh.virginia.gov/content/uploads/sites/175/2021/04/High-Burden-TB-Countries-2021.pdf

If yes, what country/countries? _____ How long? _____
Reason (please circle) Born there Tourist Work School Other _____

2. Do any of the following conditions or situations apply to you?
   a) Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? **YES** ☐ **NO** ☐
   b) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? **YES** ☐ **NO** ☐
   c) Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? **YES** ☐ **NO** ☐

Sign Here Student Signature _____ Date _____

If you answered no to all of the above questions, skip Section C, you are done.
If you answered yes to any of the above questions, your health care provider must complete Section C below.

SECTION C: ATTENTION HEALTH CARE PROVIDER: If patient answered YES to any of the above questions, proof of a PPD, QuantiFERON –TB Gold or T-SPOT is REQUIRED. If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT are positive, a chest x-ray is REQUIRED. Testing and/or chest x-ray must be done within one calendar year prior to admittance (unless history of positive PPD). If student has history of positive PPD, chest x-ray is required. History of BCG vaccination does not prevent testing of a member of a high risk group.

PPD: Date placed _____ Date read _____ # of mm induration _____

OR

QuantiFERON-TB Gold or T-SPOT: Result Date _____ Result (attach lab report) _____

OR

Date of chest x-ray _____ Result _____

If positive testing, did student complete a course of oral therapy?If yes, what type and when? **YES** ☐ **NO** ☐

_____

(months & year) and for how many months did student take oral therapy? _____ **(# of months)**

PROVIDER INFORMATION REQUIRED

_____ _____ _____
(**please print**) Name of health care provider Phone number of practice Date

_____ _____
Signature of health care provider Practice Address