



STUDENT HEALTH SERVICES

13 Oak Drive
Hamilton, NY 13346

Phone: 315-228-7750 Fax: 315-228-6823

studenthealth@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.

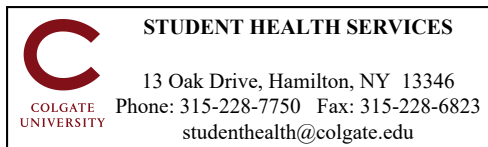
LAST NAME:	FIRST NAME, MIDDLE INITIAL:	PREFERRED FIRST NAME:	DATE OF BIRTH (MM/DD/YYYY):
COLGATE EMAIL ADDRESS:		Anticipated Year of Graduation from Colgate	

REQUIRED	MMR 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW. ADMINISTERED AFTER 1 ST BIRTHDAY		DOSE #1	DOSE #2	
	OR				
	Measles (Rubeola) 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1 ST BIRTHDAY	DOSE #1	DOSE #2	OR	LABORATORY EVIDENCE OF IMMUNITY UPLOAD LAB REPORT
	Mumps 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1 ST BIRTHDAY	DOSE #1	DOSE #2	OR	LABORATORY EVIDENCE OF IMMUNITY UPLOAD LAB REPORT
	Rubella (German Measles) 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1 ST 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	DOSE #1	DOSE #2	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) <input type="checkbox"/> HPV4 or <input type="checkbox"/> 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	



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 ☐



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 _____