CHRISTOPHER NEWPORT UNIVERSITY
OFFICE OF THE REGISTRAR

# CERTIFICATE OF IMMUNIZATION

*Note: This completed form must be mailed, delivered, emailed or faxed to the following:*
*Christopher Newport University (Christopher Newport Hall, Commons), Attn: Office of the Registrar*
*1 Avenue of the Arts, Newport News, VA 23606*
*Fax Number: (757) 594-7711*
*Email: immunizations@cnu.edu*

**Student Name**_____
Last First Middle

**CNU ID** _____ **Date of Birth** _____/_____/_____ **Email** _____

**Daytime Phone** (_____ ) _____ **Entering Semester/Year:** ☐ Spring ☐ Fall 20_____

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**Must be completed and SIGNED by a licensed healthcare provider & submitted to the Office of the Registrar.**

## PART I – IMMUNIZATION RECORD

**A. Measles, Mumps, Rubella *(required)***

1. I was born before January 1, 1957 and am considered immune Yes □ No □ *(if 'no' complete #2 or #3)*
   ***OR***
2. MMR (Measles, Mumps, Rubella)
   Two doses required: 1st Dose _____/_____/_____ ***AND*** 2nd Dose _____/_____/_____

   ***OR*** all 3 of the following criteria are met:

3. Measles (Rubeola)
   Positive immune titer ____/____/____ ***OR*** two doses of individual rubeola vaccine ____/____/____ ____/____/____

   Mumps
   Positive immune titer ____/____/____ ***OR*** one dose of individual mumps vaccine ____/____/____

   Rubella (German measles)
   Positive immune titer ____/____/____ ***OR*** one dose of individual rubella vaccine ____/____/____

**B. Tetanus-Diphtheria *(required)***
____/____/____ **(Must be within last 10 years)** ***OR*** **Tdap** ____/____/____

**C. Poliomyelitis *(required)***
1. Primary Childhood Series - date completed: _____/_____/_____ ***OR***
2. Positive immune titer _____/_____/_____ ***OR*** one dose of IPV - Date _____/_____/_____

**D Hepatitis B *(vaccinations or waiver required)***
1. Immunization (hepatitis B)
   a. Dose #1 ___/ ___/ ___ b. Dose #2 ___/ ___/ ___ c. Dose #3 ___/ ___/ ___
   ***OR***
2. Immunization (combined Hepatitis A and B vaccine)
   a. Dose #1 ___/ ___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___
   ***OR***
3. *WAIVER: I have reviewed the CDC website regarding Hepatitis B at http://www.cdc.gov/hepatitis/index.htm and have been fully informed of the risks and health hazards of Hepatitis B infection as well as the benefits of the Hepatitis B vaccine. I choose not to be immunized against Hepatitis B infection at this time.* **Signature of Waiver (student, or if under 18 parent/legal representative**: _____

**E Meningococcal Vaccine**
1. Vaccine received on _____/_____/_____ (date of vaccination) Menveo _____ Menactra _____
   **A Booster Dose is recommended (or a signed waiver) for those who received their first dose before age 16.**
   ***OR***
2. *WAIVER: I have reviewed the CDC website regarding Meningitis at http://www.cdc.gov/meningitis/index.html and have been fully informed of the risks and health hazards of Meningitis infection as well as the benefits of the Meningitis vaccine. I choose not to be vaccinated against the Meningococcal disease at this time.* **Signature of Waiver (student, or if under 18 parent/legal representative: _____**

***CONTINUE TO AND SUBMIT PAGE TWO FOR REQUIRED SIGNATURE BLOCK>>>>>>>>>>***

**Student Name**_____ **CNU ID** _____

*** PART II - Must be completed**

## TUBERCULOSIS SCREENING

**F.** The American College Health Association (ACHA) has published guidelines on tuberculosis screening of college and university students. Christopher Newport University has adopted those guidelines based on their recommendations. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/corecurr/.

1. Does the student have signs or symptoms of active TB disease? ☐ YES ☐ NO

   If **NO**, proceed to question 2.

   If **YES**, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Is the student a member of a high-risk group or is the student entering the health professions? (See footnote #1 below) ☐ YES ☐ NO

   If **NO**, stop. **No further evaluation is needed at this time.**

   If **YES**, place tuberculin skin test (Mantoux only; inject 0/1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm). A history of BCG vaccination should not preclude testing of a member of a high-risk group. If PPD is not placed, a chest x-ray is required (see #4 to record x-ray result).

3. Tuberculin Skin Test (**must have been placed within the last 12 months.)**

   Date Given _____/_____/_____ Date Read _____/_____/_____

   Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")

   Interpretation (based on mm in induration as well as risk factors): ☐ Positive ☐ Negative

4. Chest x-ray (required if tuberculin skin test is positive or if PPD has not been placed for any reason):

   Date of chest x-ray: _____/_____/_____ Result: ☐ Normal ☐ Abnormal

[1]Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemia or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone $\geq$ 15 mg/d for $\geq$ 1 month) or other immunosupressive disorders.

*** REQUIRED SIGNATURE BLOCK**

_____

**REQUIRED Signature OR Signature Stamp of Licensed Health Professional * ****See Part II above** *** **Date**

_____

**Print Name** **Address** **Phone**

**MEDICAL EXEMPTION:** _____Td _____ IPV _____ Measles _____ Rubella _____ Mumps _____ Meningococcal

G. As specified in Section 12VAC5-110-80 of the Code of Virginia, I certify that the administration of the vaccine(s) designated above would be detrimental to this student's health. This contraindication is (circle one) permanent / temporary and is expected to preclude immunization until _____, unless an emergency or epidemic of disease has been declared by the Board of Health.

_____

Signature of Licensed Health Professional Date of Signature

**RELIGIOUS EXEMPTION FOR ALL IMMUNIZATIONS**

H. Section 12VAC5-110-80 of the Code of Virginia states "Any student shall be exempt from the immunization requirement who objects on the grounds that administration of immunizing agents conflicts with his/her religious tenets or practice, unless an emergency or epidemic of disease has been declared by the Board of Health." Such students must submit a "Certification of Religious Exemption" (form CRE-1), which may be obtained via http://www.doe.virginia.gov/support/health_medical/certificate_religious_exemption.pdf.

**OFFICE of the RESISTRAR USE ONLY** Date Processed: _____ Initials: _____ Notes: