

James Madison University Immunization Form

COMMONWEALTH OF VIRGINIA LAW REQUIRES THAT THE CERTIFICATE OF IMMUNIZATION AND TB SCREENING BE COMPLETED AND SUBMITTED TO THE UNIVERSITY HEALTH CENTER.

Instructions for new students:

- Download (if PDF does not display correctly, open the file in Adobe Reader) and print the Immunization Form and have it completed and signed by a health care professional. An official immunization record from your doctor or another school will be accepted.
- Log into your MyJMUHealth account to upload the completed and signed immunization form (or official record), as well as a copy of your health insurance card (front and back.) ALL UPLOADED FORMS MUST BE IN .pdf FORMAT.
- Complete the required TB Assessment for Incoming Student and the Health History located under the "forms" tab in MyJMUHealth.

Due dates for undergraduate students: July 6, 2018 for Fall 2018 semester start.

Due date for graduate students: No later than the third Friday of the first semester attending JMU.

Immunizations must be up-to-date. Failure to complete this process will result in an academic hold on your student account and a \$50 fine.

CERTIFICATE OF IMMUNIZATION*

This MUST be signed by a health care provider

Name (print): _____ Date of Birth: ____/____/____

Date completed: ____/____/____ STUDENT ID NUMBER: _____

REQUIRED IMMUNIZATIONS			
Tetanus, Diphtheria vaccine Has Tdap ever been given to this patient? Yes No	Date of most recent Tetanus containing vaccination (*Must be within the past 10 years) Date: (MM/DD/YY) ____/____/____		
Hepatitis B (For combined Hep. A + B, do not use this line. Instead, check here: ____ and complete the appropriate line in "Recommended but Not Required")	Indicate: 2-dose__ or 3-dose__ series	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____ Date: (MM/DD/YY) 3) ____/____/____
Meningococcal Vaccine: ** Initial dose OR a booster dose must have been received on or after their 16th birthday	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	If applicable, booster ≥ 16 years old Date: (MM/DD/YY) ____/____/____
Measles, Mumps, Rubella (MMR) Students born before 1957 are not required to have a second MMR vaccination.	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____ OR Titer (Attach Copy)	
Poliomyelitis (OPV) or (IPV)	Date: (MM/DD/YY) ____/____/____		
TB Screening	Student must complete questionnaire online at MyJMUHealth		

RECOMMENDED BUT NOT REQUIRED			
HPV (Quadrivalent or Bivalent) <input type="checkbox"/> CERVARIX or GARDASIL <input type="checkbox"/> GARDASIL9	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	Date: (MM/DD/YY) 3) ____/____/____
Hepatitis A	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	
Meningococcal B Vaccine (__ MenB-4C OR __ MenB-FHpb)	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	Date: (MM/DD/YY) 3) ____/____/____
Varicella <input type="checkbox"/> had disease (two doses one month apart for adults with no history of the disease)	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	OR Titer (Attach Copy)

This form will not be accepted if not signed by a health care provider.

HEALTH CARE PROVIDER SIGNATURE (Dr., Nurse, NP, PA, DO)

Printed Name _____ Phone _____

Address _____

Signature _____ Date _____

JMU Health Center Staff only Reviewed: _____ Reviewed by: _____ Notified: Compliant Non-Compliant