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:

1. 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.
2. 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. **Immunizations must be up-to-date.**
3. Complete the required TB Assessment for Incoming Student and the Health History located under the "forms" tab in MyJMUHealth.

Due dates for undergraduate students: December 7, 2018 for Spring 2019 semester start.
Due date for graduate students: No later than the third Friday of the first semester attending JMU.

An enrollment hold and a $50 fine will be placed on your account if your immunization form and TB Screening are not deemed complete by the Health Center staff.

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) ☐ **CERVARIX or GARDASIL** ☐ **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 ☐ **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 (MD, DO, NP, PA, Nurse)

Printed Name _____ Phone _____

Address _____

Signature _____ Date _____

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