

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 and Health History for NEW students located under the "forms" tab in MyJMUHealth.

Due dates for undergraduate students: July 8, 2019 for Fall 2019 semester start and December 13, 2019 for Spring 2020 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	Check one: ___ 2-dose series ___ 3-dose series ___ Combined A+B	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 <u>on or after their 16th birthday</u>	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