

James Madison University Immunization Form

COMMONWEALTH OF VIRGINIA LAW REQUIRES THAT THE **CERTIFICATE OF IMMUNIZATION AND TB ASSESSMENT FORM** BE COMPLETED AND SUBMITTED TO THE UNIVERSITY HEALTH CENTER. **An official immunization record from your doctor or another school will be accepted**

Instructions for new students:

1. Log onto MyJMUChart
 - a. Check the status of your immunizations under the Immunization tab. If your status is "Not Compliant" or "No Data" follow the instructions on the immunization page. If your status is "Verified" your record is complete.
 - b. Complete the TB Assessment for new incoming students under the Forms tab.
 - c. Enter your insurance information and upload a photo of your card under the Insurance tab.
 - d. If you are requested to submit immunization documentation, that can be done under the Upload tab.
2. Continue checking your JMU email and secure messages on MyJMUChart for confirmation that your record has been verified and is complete. Your pre-entry health requirements are not complete until you receive that confirmation.

Due dates for undergraduate students: July 6, 2025 for Fall 2025 semester start and January 5, 2026 for Spring 2026 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 Assessment Form are not deemed complete by the Health Center staff.

CERTIFICATE OF IMMUNIZATION*

This MUST be signed by a health care provider if this form is completed

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 <input type="checkbox"/> Combination Hepatitis A and B vaccine	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	Date: (MM/DD/YY) 3) ____/____/____	OR Titer (Attach Copy)
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. First dose AFTER 1 st birthday	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	OR Titer (Attach Copy)	
TB Assessment Form	Student must complete online form on MyJMUChart			
STRONGLY RECOMMENDED BUT NOT REQUIRED				
COVID-19 (most recent vaccine)	Date: (MM/DD/YY) ____/____/____	Influenza (most recent vaccine)	Date: (MM/DD/YY) ____/____/____	
HPV (Quadrivalent or Bivalent)	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) ____/____/____	
Polio (only last dose received)	Date: (MM/DD/YY) ____/____/____			
Varicella <input type="checkbox"/> had disease OR (2 doses one month apart for adults with no history of disease)	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	OR Titer (Attach Copy)	

HEALTH CARE PROVIDER SIGNATURE (Dr., Nurse, NP, PA, DO) *This form will not be accepted if not signed by a health care provider.*

Printed Name _____ Phone _____

Address _____

Signature _____ Date _____