Highlands College

IMMUNIZATION RECORD

Required of all Traditional students – Due two weeks prior to arrival/classes

NAME_____
Last *First* *Middle*

DATE OF BIRTH ____ /____ /____
month day year

Email address:_____ **Phone number: (____)____-_____**

Enrolling: ☐Fall ☐ Spring **Year** 20___ **Program of Study:** _____ **Living in Campus Housing?** Yes [ ] No [ ]

TUBERCULOSIS SCREENING (student must answer BOTH screening questions)

1. Does the student have signs or symptoms of active tuberculosis disease? (symptoms include: persistent , coughing up blood, fever, fatigue, unexplained weight loss, etc.)

Yes [ ] No [ ] **If No, proceed to 2. If yes, proceed to #3** for additional evaluation to exclude active tuberculosis disease.

2. Is the student a member of a high risk group or is the student entering a health profession? Yes [ ] No [ ] If No, stop. If yes, proceed below.

-**High risk students include** those who have arrived within the past 5 years from any country EXCEPT: Western Europe, Canada, Australia or New Zealand. Additional high-risk categories include those with HIV infection or other immunosuppressive disorders, h/o IV drug use, or those who have resided in, or worked in high-risk congregate settings such as prisons, shelters, hospitals, nursing homes, etc.

-**Also includes** students currently working in a healthcare setting or entering into the clinical portion of a health profession field of study; does not include pre-requisite courses

3. If the student answers **'yes' to either of the questions above**, please proceed with the Tuberculosis screening:

a. PPD Skin Test (Mantoux): Must be within 6 months of entrance date.

Date Given: _____ month/day/year Date Read: _____ month/day/year Results: (mm induration) _____ **If positive, report to Health Department for further evaluation (chest x-ray and IGRA)**

b. Healthcare workers/students require a **one-time** 2-step PPD Skin Test (must be at least 1 but no greater than 3 weeks after the first skin test)

Date Given: _____ month/day/year Date Read: _____ month/day/year Results: (mm induration) _____ **If positive, report to Health Department for further evaluation (chest x-ray and IGRA)**

OR

c. IGRA (Quantiferon gold or T-spot) accepted in lieu of TB Skin test within 6 months of entrance **for students with history of positive TB Skin test**.

- Must provide copy of lab report, chest x-ray report of negative findings, and the Highlands College TB questionnaire. **Result** _____ **Date** _____

OR

d. Chest x-ray (required **if student has history of latent or active TB disease***) -Date of Chest x-ray (must be within 6 months of entrance): _____

-Results: Normal [ ] Abnormal [ ]

-Must attach documentation of treatment, chest x-ray report, and TB questionnaire.

VACCINATIONS REQUIRED OF ALL STUDENTS:

M.M.R. (Measles, Mumps and Rubella)

Born before 1957, no MMR immunization required

Combined Vaccines (Two doses; at least one month apart)

	#1	#2
M.M.R (Measles,Mumps,Rubella)	____/____/____ month day year	____/____/____ month day year

OR

Laboratory Evidence of Immunity (all 3 required) in lieu of vaccines

*must submit copy of lab report

*if not immune, please complete the vaccination series

Measles	#1 ____/____/____ month day year	RESULT: [ ] Immune [ ] Non-Immune
Mumps	#1 ____/____/____ month day year	RESULT: [ ] Immune [ ] Non-Immune
Rubella	#1 ____/____/____ month day year	RESULT: [ ] Immune [ ] Non-Immune

OR

Individually Administered Vaccines

Measles	#1 ____/____/____ month day year	#2 ____/____/____ month day year
Mumps	#1 ____/____/____ month day year	
Rubella	#1 ____/____/____ month day year	

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IMMUNIZATION RECORD *continued*

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VACCINATIONS REQUIRED OF STUDENTS LIVING IN HOUSING:

Tdap (TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS) At least one dose required within the last 10 years. ___/___/___ Month Day Year

VARICELLA (Chickenpox**)**

History of Disease	___/___/___ Month Day Year (Minimum Month/ Year as date accepted) please provide laboratory evidence of immunity if date not available)

OR

Immunizations (Two doses required)	#1 ___/___/___ Month Day Year	#2 ___/___/___ Month Day Year

OR

Laboratory Evidence of Immunity* ___/___/___ Month Day Year RESULT: [ ] Immune [ ] Non-Immune

* must provide copy of lab report

* if not immune, please complete the vaccination series

MENINGOCOCCAL (quadrivalent - A,C,Y, W-135) (must have one dose since 16th birthday)

Immunization	___/___/___ Month Day Year

RECOMMENDED VACCINATIONS:

HEPATITIS B - *REQUIRED FOR STUDENTS LIVING IN HOUSING*

Immunizations

#1 ___/___/___ Month Day Year	#2 (at least one month after dose #1) ___/___/___ Month Day Year	#3 (at least six months after dose #1 OR four months after dose #2) ___/___/___ Month Day Year

OR

Laboratory Evidence of Immunity*

Hepatitis B Surface Antibody *(*must provide copy of lab report)*	___/___/___ Month Day Year	RESULT: [ ] Immune [ ] Non-Immune

THIS SECTION TO BE FILLED OUT BY HEALTH CARE PROVIDER ONLY *Student Health Information*

Please list any potential communicable illnesses: _____

_____

MD/PA/NP Signature: _____ Date: _____

Print Name: _____ Phone: (_____) _____-_____

Address: _____

Please submit to: admissions@highlandscollege.com OR mail to Highlands College / 3660 Grandview Parkway / Birmingham, AL 35243