Student Immunization Record

Welcome to Bob Jones University! We are glad you have chosen us to meet your Christian higher education goals.

Please complete the Student Immunization Record and TB Screening Questionnaire and upload both completed forms to your application status page. You can also email your forms to studenthealth@bju.edu or fax to 864-242-2543.

According to university policy, the immunization requirements must be met and a copy will be kept on file in the Student Health Office.

If you are unable to obtain all required immunizations before your arrival on campus, there are local Urgent Care providers near the University where they may be obtained.

Instructions for Completing Immunization Record Form and TB Screening Questionnaire

Sections A, B & C
Required immunizations. Have your clinician fill in your immunization record and update any needed immunizations that are required in sections A, B and C.

Section C
The State of South Carolina requires higher education institutions to inform students and parents of the risk of contracting these diseases and the availability of preventative vaccines. Bob Jones University encourages all students, parents and guardians to learn more about these serious communicable diseases and to make informed decisions regarding protection.

Section D
A medical exemption is allowed on the grounds of permanent contraindications/adverse reaction.

Special Forms
• Tuberculosis (TB) Screening Questionnaire
  All students are required to complete and return this questionnaire to determine if a TB test (screen) is needed.
• Religious/Philosophical Exemption Form (if needed)

Other Acceptable Records of Your Immunizations (Student’s full name must be on all documents.)
• Personal shot records that are verified by a doctor’s stamp or health provider’s signature.
• Personal shot records with a clinic or health department stamp.
• Military records.
• Previous college or university records that are verified — a copy must be requested and transferred to BJU.
• Positive laboratory test as confirmation of immunity.
• State immunization records — Contact the IIS (Immunization Information Systems) in your state or in the state where you or your child received the shots to see if they have your records.
BJU Student Immunization Record

Name __________________________________________________________
Date of birth ____________________________________________________

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER or PROVIDE AN ACCEPTABLE COPY OF YOUR RECORD

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA)
1. Dose 1 given at age 12 months or later. #1 / / 
2. Dose 2 given at least 28 days after first dose. #2 / / 

B. Tdap - (TETANUS, DIPHTHERIA, PERTUSSIS) Required in last 10 years
☐ Adacel  ☐ Boostrix
Date / / 

C. HEPATITIS B and MENINGOCOCCAL MENINGITIS
The State of South Carolina requires higher education institutions to inform students and parents about the risk of contracting these diseases and the availability of preventive vaccines. Prior to declining the Hepatitis B or the Meningococcal Vaccine, please read the information provided at the following websites: Meningococcal Vaccination: www.cdc.gov/vaccines/vpd/mening/public/index.html; Hepatitis B Vaccination: www.cdc.gov/vaccines/vpd/hepb/index.html; Consult your family physician or local health department for more information.

Hepatitis B Vaccine (series of three vaccinations or a positive titer — attach a copy of results). May be combined with Hepatitis A.

☐ I have read the information at CDC.gov/vaccines and decline to receive the Hepatitis B vaccine.

Applicant’s signature or parent or legal guardian’s signature if applicant is under 18

Meningococcal Vaccine

Meningococcal ACWY (Date given) _______________ (Age) ________  (Date given) _______________ (Age) ________
OR Meningococcal B (Date given) _______________ (Age) ________ Booster _________________ (Date given) _______________

☐ I have read the information at CDC.gov/vaccines and decline to receive the Meningitis vaccine.

Applicant’s signature or parent or legal guardian’s signature if applicant is under 18

D. EXEMPTION This student is exempt from the following immunizations on the grounds of permanent contraindication/adverse reaction.

______________________________________________________________
Attach documentation.

HEALTH CARE PROVIDER SIGNATURE OR STAMP REQUIRED

Name _______________________ Signature/Stamp ______________________ Address _______________________ Phone _______________________ 

After completing this form, please upload to your Application Status Page or send to studenthealth@bju.edu/Fax: (864) 242-2543. (24185) 2/23
Tuberculosis (TB) Screening Questionnaire: Part I (to be completed by all incoming students)

Please answer the following questions (in reference to the TB endemic countries listed below which have a high incidence of active TB disease):

1. Have you ever had close contact with persons known or suspected to have active TB disease? □YES □NO

2. Were you born in one of the countries or territories listed below? (If YES, please CIRCLE the country below.)
   □YES □NO

3. Have you resided (within the past 5 years) in one of the countries or territories listed below? (If YES, please CIRCLE the country below.)
   □YES □NO

4. Have you had frequent or prolonged visits to one or more of the countries or territories listed below? (If YES, CHECK the countries or territory.)
   □YES □NO

5. Have you been a resident, volunteer and/or employee of high-risk congregate settings (e.g., correctional facilities, long term care facilities or homeless shelters)? □YES □NO

6. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? □YES □NO

Angola  Eswatini  Kyrgyzstan  Guinea  Thailand
Azerbaijan  Ethiopia  Lesotho  Peru  Uganda
Bangladesh  Gabon  Liberia  Philippines  Ukraine
Belarus  Guinea  Malawi  Republic of Moldova  United Republic of Tanzania
Botswana  Guinea-Bissau  Mongolia  Russian Federation  Uzbekistan
Brazil  India  Mozambique  Sierra Leone  Vietnam
Cameroon  Indonesia  Myanmar  Somalia  Zambia
Central African Republic China  Kazakhstan  Namibia  South Africa  Zimbabwe
Congo (Democratic People's Republic of)  Korea (Democratic People's Republic of)  Nepal  Papua New  Tajikistan

IF THE ANSWER TO ALL OF THE ABOVE QUESTIONS IS NO, no further testing is required.

IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS, Bob Jones University requires that you receive TB testing as soon as possible. The TB test must be completed in the U.S. within the last year. (TB screenings performed outside of the U.S. will not be accepted.)

After completing this form, please upload to your Application Status Page or send to studenthealth@bju.edu/Fax: (864) 242-2543.
Clinical Assessment by Health Care Provider: Part II

To be completed only if TB testing is required. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below.) □Yes □No
History of BCG vaccination? (If yes, consider IGRA or Chest X-ray.) □Yes □No

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? □Yes □No
If No, proceed to 2 or 3
If yes, check below:
☐ Cough (especially if lasting for three weeks or longer) with or without sputum production
☐ Coughing up blood (hemoptysis)
☐ Chest pain
☐ Loss of appetite
☐ Unexplained weight loss
☐ Night sweats
☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest X-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0.” The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given / / Date Read / /
Result: mm of induration **Interpretation: positive negative

3. Interferon Gamma Release Assay (IGRA)

Date Obtained / / (specify method) QFT-GIT T-Spot other

Result: negative positive indeterminate borderline (T-Spot only)

4. Chest X-ray (Required if TST or IGRA is positive)

Date of chest X-ray / / Result: normal abnormal

Health Care Professional Signature/Stamp Date

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