BOB JONES UNIVERSITY
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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 enclosed Student Immunization Record and TB Screening Questionnaire and send to hlthform@bju.edu, Fax: (864) 271-4342, or mail: Risk Management, Bob Jones University, 1700 Wade Hampton Blvd., Greenville, SC 29614

Guidelines for Completing Immunization Records and TB Screening Questionnaire

According to university policy, the immunization requirements must be met and on file at the Office of Admission. 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.

Acceptable Records of Your Immunizations

- 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 in your state or in the state where you or your child received the shots to see if they have your records)

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 asked to complete this questionnaire to determine if a TB test (screen) is required.
- Religious/Philosophical Exemption Form

After completing this form, please send to hlthform@bju.edu / Fax: (864) 271-4342, or mail: Risk Management, Bob Jones University, 1700 Wade Hampton Blvd., Greenville, SC 29614

BJU Student Immunization Record

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Name _____
Address _____
City State ZIP

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

All information must be in English.

Tips on getting copies of Immunization Records:
1. Contact your family physician or pediatrician.
2. Contact the clinic or hospital where shots were given.
3. Call your elementary, middle or high school, previous college or university for copies of immunizations.
4. Contact the Immunization Information System (IIS). www.cdc.gov/vaccines/programs/iis/contacts-locate-records.html

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. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? ☐ Yes ☐ No Date of last dose in series: ____/____/____ (M D Y)

2. Date of most recent booster dose: ____/____/____ (M D Y) Type of booster: Td _____ Tdap _____

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; Immunization Recommendations for College Students: www.acha.org/documents/resources/guidelines/ACHA_Immunization_Recommendations_Oct2018.pdf **or 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.

Hep B (Date given) _____ (Date given) _____ (Date given) _____

☐ I have read the information at CDC.gov/vaccines or acha.org/guidelines 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

Menveo (Date given) _____ (Age) _____ OR Menactra (Date given) _____ (Age) _____

OR Trumemba (Date given) _____ (Age) _____ Booster _____ (Date given) _____

☐ I have read the information at CDC.gov/vaccines or acha.org/guidelines 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

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(23301) 6/21

TB Screening Record: Name_____

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Tuberculosis (TB) Screening Questionnaire

Part I: (to be completed by all incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ☐Yes ☐No

Were you born or have you resided **(within the past 5 years)** in one of the countries or territories listed below, which have a high incidence of active TB disease? (If yes, please CIRCLE the country below) ☐Yes ☐No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
São Tomé and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Vietnam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to www.who.int/tb/country/en/.

Have you had prolonged visits to one or more of the countries or territories listed above, with a high prevalence of TB disease? (If yes, CHECK the countries or territories above) ☐Yes ☐No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities and homeless shelters)? ☐Yes ☐No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ☐Yes ☐No

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.)

If the answer to all of the above questions is NO, no further testing or further action is required.

TB Screening Record: Name _____

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Clinical Assessment by Health Care Provider
Part II:

Clinicians should review and verify the information in Part I. 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