University Life
STUDENT HEALTH SERVICES
George Mason University

Certificate of Immunization

_____ _____ _____
Student Legal Last Name (surname) Student Legal First Name Date of Birth (MM/DD/YYYY)

Student ID (G)#: _____ Country of Birth: _____ Mobile #: _____

Mason Start Date (Semester, Year): _____
Enter Fall, Spring, Summer semester

Visit shs.gmu.edu/immunizations for detailed instructions, FAQs, Immunization Office hours & info.

Student Instructions

1. Download and print Certificate of Immunization. Complete student sections.
2. Take this form and supporting immunization documents to a healthcare provider. This form is required to be completed and signed by a healthcare professional.
3. Submit completed form and support documents by deadline listed online at shs.gmu.edu/immunizations.
4. Check compliance status in Patient Portal after submission & processing. If not in compliance, submit needed documentation.

Requirements

- ALL students must complete Part 1: Tuberculosis (TB) Screening Questionnaire (page 2).
- ALL students born after 12/31/1956 must provide accepted proof of immunizations listed in Part 3 (page 4).
- Healthcare provider must complete and sign ('transcribe') Part 2*, Part 3, Part 4, and Part 5*. *(*if applicable)*
  - If you do not have a healthcare provider, you can complete the Transcription Consent below to have this service with Student Health Services for a fee.
- Patient's legal name and date of birth must be on all document pages, titer lab reports, x-ray reports, and records.
- All support documents or records must be in English. If not in English, must provide certified translation.
- **A $50 late fee & hold will be placed on the student account if the Certificate of Immunization & requirements are not deemed complete by the Student Health immunization staff by listed deadlines.**

How to submit Certificate of Immunization and support documents

- **Preferred Method: Upload to the Patient Portal at https://gmu.medicatconnect.com.** Scan or take photo of documents and save to your device. Follow instructions on Upload page in Portal.
- Or Mail to: George Mason University Student Health Services, 4400 University Drive, MS 2D3, Fairfax, VA 22030 *(Mailed forms must be received by deadline. Keep copies of documents.)*

After submission – log into Patient Portal to check status

- Immunization Office will process submission. It can take between 7 – 14 business days to process.
- Students will be notified regarding compliance/non-compliance. The student will get an email to their Mason email. It will state you have a secure message and should log into the Patient Portal. These messages may go to spam/junk. Go to Messages in the Portal to review compliance status.

Student Disclosure: Student Health Services reserves the right to request supporting documentation of your immunization records and request titers and/or vaccinations at your expense.

Transcription Service Consent: For info on Transcription Service visit shs.gmu.edu/immunizations/transcription-service. Upload completed student sections of the Certificate of Immunization & support documents to Portal for service.

By signing below, I request to have my form transcribed by Student Health Services. I agree to pay the $20 fee.

Student/Parent/Guardian Signature: _____ Date: _____

Student Name: _____ G#:_____ Date of Birth: _____

PART 1: TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Instructions: Questionnaire required for all students. Student must answer ALL questions below & sign. Blue or black ink only. List countries where indicated. Select Yes or No for response to questions 2 – 8.

1. List the country where you were born: _____

2. Have you ever tested positive for TB (tuberculosis)? ☐ Yes ☐ No
   If yes: healthcare provider must complete Part 2. Student must provide documentation of a positive TB test (historical or current) and documentation of a chest x-ray dated within 3 months of classes starting.
   If no: go to question 3.

3. Have you ever lived or traveled in any country other than the United States for more than a month at a time? ☐ Yes ☐ No

   List the countries you have you lived in: _____

   List the countries you have you traveled to: _____

4. Do you have an immuno-suppressive disease? ☐ Yes ☐ No
   Persons who are receiving immune-suppressive medications such as corticosteroid or drug therapy following organ transplantation and persons with immune-suppressive conditions such as HIV, diabetes mellitus, chronic renal failure, leukemia, or cancer.

5. Have you ever received a Bacillus Calmette-Guerin (BCG) vaccine (TB vaccine)? ☐ Yes ☐ No

6. Have you had close contact with anyone who is or was sick with TB? ☐ Yes ☐ No

7. Have you resided in, volunteered or worked in a prison, nursing home, hospital, or homeless shelter? ☐ Yes ☐ No

8. Do you have any symptoms of active TB, such as a cough longer than 3 weeks, night sweats, fever unexplained weight loss and/or fatigue? ☐ Yes ☐ No

I affirm that all the above information is accurate.

Student/Parent/Guardian Signature: _____ Date: _____

If you answer “Yes” to any of the above questions a healthcare provider must complete Part 2: Assessment & Tuberculosis Testing by a healthcare provider on page 3.

Student Name: _____ G#:_____ Date of Birth: _____

PART 2: ASSESSMENT & TUBERCULOSIS TESTING BY A HEALTHCARE PROVIDER

- Review Part 1: TB Screening Questionnaire. If answers to all questions in Part 1 are NO, further testing is not indicated.
- Provide copies of reports as specified below. Reports must be in English and include patient's full name and date of birth.
- TB tests (if not historical) and/or chest x-ray (if required) must be within 3 months of class start date - dated after May 1st of the current year for Fall enrollment and October 1st of previous year for Spring enrollment. Testing completed too early or with invalid results may require repeat testing.
- Student should upload documentation to Mason's Health Services Patient Portal.

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1. Patient history of BCG? ☐No ☐ Yes

2. TB risk assessment completed by provider? ☐No ☐ Yes, date: _____

If no TB test is required, provide copy of completed risk assessment to student

If risk assessment is positive, please proceed.

3a. Patient does NOT have a history of POSITIVE IGRA (QFT or T-spot) or Tuberculin Skin Test (TST)
Student must receive either an IGRA or TST within 3 months of classes start date.

Interferon Gamma Release Assay (IGRA) - Preferred test: must provide copy of the lab report. Test must be within 3 months of classes start date.

Date Obtained:____/____/_____ (MM/DD/YYYY) Specify test: ☐QFT ☐T-spot ☐ Other_____

Result: ___ Positive (**go to 3b**) ____ Negative ___ Other:_____

TUBERCULIN SKIN TEST (TST) - TST result must be recorded in millimeters [mm] of induration, transverse diameter; if no induration, write "0." The TST interpretation is based on induration and risk factors.** Test must be within 3 months of classes start date.

Date Placed: ____/____/_____ (MM/DD/YYYY) Date Read: ____/____/_____ (MM/DD/YYYY)

Results in mm of induration: _____

****INTERPRETATION GUIDELINES: >10 mm is positive:**
• recent arrivals to the U.S. (<5 years) from high-prevalence areas or who resided in one for a significant* amount of time

Interpretation: ___ Positive (go to 3b**) ___ Negative

3b. Patient has a history of POSITIVE IGRA (QFT or T-spot) or Tuberculin Skin Test (TST). Proceed to 4.
Student must provide copy of historical positive results and have a chest x-ray within 3 months of classes start date.

4. CHEST X-RAY: REQUIRED IF DOCUMENTATION OF POSITIVE IGRA OR TST.
Must provide a copy of the chest x-ray report dated after May 1st of the current year for Fall enrollment and October 1st of previous year for Spring enrollment. Must include patient's full name and date of birth.

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5. Has patient taken medication(s) for TB infection? ☐No ☐ Yes - List Medication(s):_____

Date Began Medication: ___/____/_____ (MM/DD/YYYY) Date Medication completed: ___/____/_____ (MM/DD/YYYY)

All students with a positive IGRA or TST and no signs of active disease on chest x-ray should receive education and treatment recommendations for Latent Tuberculosis Infection (LTBI). LTBI must be reported to local health department.
Further information for Virginia TB, visit vdh.virginia.gov/tuberculosis/

This form will not be accepted if not signed by a healthcare provider (MD, DO, NP, PA, Nurse). Use stamp for facility information.

Provider Printed Name and Credentials: _____

Provider Signature: _____ Date:_____

Phone: _____ Healthcare Facility Stamp:
(Facility Name, Address)

Student Name: _____ G#:_____ Date of Birth: _____

PART 3: REQUIRED IMMUNIZATIONS

- A Healthcare Provider (MD, DO, NP, PA, Nurse) must complete & sign form in blue or black ink. “See attached" is not acceptable documentation. All dates must be entered onto form (check marks not acceptable).
- Provide copies of titer reports. Must be in English. Must include patient’s full name and date of birth.
- Student should upload to the Health Services Patient Portal.

Hepatitis B - Must receive a complete series, or attach positive titer, or sign waiver **3 doses** ____ Hepatis B **3 doses** ____ Twinrix **2 doses** _____ Heplisav	Date ___/____/_____ (MM/DD/YYYY)	Date ___/____/_____ (MM/DD/YYYY)	Date ___/____/_____ (MM/DD/YYYY)	☐ OR Titer Report of Immunity	☐ OR Waiver pg. 5
Measles, Mumps, Rubella (MMR)	Dose must be after 1st birthday ____/_____/_____ (MM/DD/YYYY)	2nd dose at least 28 days later ____/_____/_____ (MM/DD/YYYY)		☐ OR Titer Report of Immunity	
OR Individual Measles - 2 doses at least 1 month apart	____/____/_____ (MM/DD/YYYY)	____/____/_____ (MM/DD/YYYY)		☐ OR Titer Report of Immunity	
OR Individual Mumps - 2 doses at least 1 month apart	____/____/_____ (MM/DD/YYYY)	____/____/_____ (MM/DD/YYYY)		☐ OR Titer Report of Immunity	
OR Individual Rubella - 1 dose	____/____/_____ (MM/DD/YYYY)	☐ OR Titer Report of Immunity			
Meningococcal Vaccine (ACWY) Administered on or after the age of 16 or student over age 21 or sign waiver	____/____/_____ (MM/DD/YYYY)	____/____/_____ (MM/DD/YYYY)	☐ Patient aged 21 or older	☐ OR Waiver pg. 5	
Poliomyelitis Last dose on or after age 4 ____OPV ___IPV	Date of last dose ____/_____/_____ (MM/DD/YYYY)	☐ Yes, patient completed series			
Tetanus, Diphtheria vaccine Within past 10 years. _____Td ___Tdap	____/____/_____ (MM/DD/YYYY)				

PART 4: STRONGLY RECOMMENDED BUT NOT REQUIRED IMMUNIZATIONS

COVID-19 List Manufacturer (ex: Pfizer, Moderna)	____/_____/_____ (MM/DD/YYYY) Mfr:_____	____/_____/_____ (MM/DD/YYYY) Mfr:_____	____/_____/_____ (MM/DD/YYYY) Mfr:_____
Hepatitis A	____/_____/_____ (MM/DD/YYYY)	____/_____/_____ (MM/DD/YYYY)	☐ Titer Report
Human Papilloma Virus ____ HPV4 ____ HPV9	____/_____/_____ (MM/DD/YYYY)	____/_____/_____ (MM/DD/YYYY)	____/_____/_____ (MM/DD/YYYY)
Influenza (most recent)	____/_____/_____ (MM/DD/YYYY)		
Meningococcal B Vaccine ____ Bexsero ____ Trumenba	____/_____/_____ (MM/DD/YYYY)	____/_____/_____ (MM/DD/YYYY)	____/_____/_____ (MM/DD/YYYY)
Varicella	____/_____/_____ (MM/DD/YYYY)	____/_____/_____ (MM/DD/YYYY)	☐ Titer Report

This form will not be accepted if not signed by a healthcare provider (MD, DO, NP, PA, Nurse). Use stamp for facility information.

Provider Printed Name and Credentials: _____

Provider Signature: _____ Date:_____

Phone: _____

Healthcare Facility Stamp:
(Facility Name, Address)

Student Name: _____ G#:_____ Date of Birth: _____

PART 5: MINOR CONSENT, WAIVERS, AND EXEMPTIONS (if applicable)

INSTRUCTIONS:

- Complete applicable sections.
- Student, or parent/guardian if student is a minor, sign applicable sections. Use blue or black ink.
- Student should upload to Health Services Patient Portal.

Minor Consent - only required if student is 17 or younger

Parental permission or the consent of a legal guardian must be obtained to provide medical or surgical care for minors. To avoid delays in treatment in the event of an illness or accident, please obtain the signature of a parent/legal guardian if you are 17 or younger at the time of submission.

I hereby authorize the staff of George Mason University Student Health Services to assess, test, administer vaccines, and if necessary, treat my minor or dependent as deemed advisable.

Parent/Guardian Signature: _____ Date: _____

PRINT Parent/Guardian Name: _____ Relationship to student: _____

Hepatitis B Vaccine Waiver

Read CDC website Hepatitis B information: cdc.gov/vaccines/vpd/hepb

I have read and reviewed information on the risk associated with hepatitis B disease, availability, and effectiveness of any vaccine against hepatitis B disease and I choose not to be vaccinated against hepatitis B disease.

_____ _____
Signature of Student or Parent/Guardian Date

Meningococcal Vaccine Waiver

Read CDC website Meningococcal information: cdc.gov/meningococcal/

I have read and reviewed information on the risk associated with meningococcal disease, availability, and effectiveness of any vaccine against meningococcal disease and I choose not to be vaccinated against meningococcal disease.

_____ _____
Signature of Student or Parent/Guardian Date

Religious Exemption

Tuberculosis screening required regardless of exemption.

Any student who objects on the grounds that administration of immunizing agents conflicts with their religious tenets or practices shall be exempt from the immunization requirements unless an emergency or epidemic of disease has been declared by the Board of Health.

A sworn statement of religious exemption must be submitted on the George Mason University *Certificate of Religious Exemption* Form found on the Student Health Services website at shs.gmu.edu/about/forms.

Student Name: _____ G#:_____ Date of Birth: _____

Part 5 cont. Medical Exemption (if applicable)

Tuberculosis Screening required regardless of exemption

INSTRUCTIONS:

- A Healthcare Provider (MD, DO) must complete & sign form in blue or black ink. All dates must be entered onto form.
- Student should upload into Health Services Patient Portal.

As specified in the Code of Virginia § 23.1-800 D (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health.

Please mark the vaccine(s) that the proposed medical exemption(s) applies to:

☐ Hepatitis B	☐ Temporary until date: _____	☐ Permanent
☐ MMR	☐ Temporary until date: _____	☐ Permanent
☐ Meningitis (ACWY)	☐ Temporary until date: _____	☐ Permanent
☐ Td	☐ Temporary until date: _____	☐ Permanent
☐ Polio	☐ Temporary until date: _____	☐ Permanent
☐ _____	☐ Temporary until date: _____	☐ Permanent

Additional Information: _____

_____

I understand, that in the occurrence of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease, the State Health Commissioner may order the student's exclusion from school, for their own protection, until the danger has passed.

This form will only be accepted if signed by a licensed physician (MD, DO). Use stamp for facility information.

Licensed Physician Printed Name and Credentials: _____

Licensed Physician Signature:_____ Date:_____

Phone: _____

Healthcare Facility Stamp:
(Facility Name, Address)