MOREHOUSE SCHOOL OF MEDICINE

Morehouse School of Medicine Immunization Form

Effective Nov 2012, all incoming students/residents must meet the CDC and American College Health Association immunization guidelines ***prior to registration for classes****. Please be sure to* ***have the form verified by the signature of your licensed healthcare provider or enclose a copy of your official, signed immunization records****. If for any reason you or your providers feel that you cannot comply with any of the requirements, please attach a letter of explanation signed by both you and your healthcare provider. For additional information or questions, please contact Student Employee Health Services - Infection Control at 404.756.1241.* ***NOTE: It is acceptable to attach your health care provider's documents or standard immunization record to this form that validate required information.***

Name _____ _____
First Name Middle Name

_____ _____
Last Name Social Security Number (Optional)

Address _____
Street City State Zip

Date of Entry ___/_____ Date of Birth ___/___/_____ MSM ID# _____
M Y M D Y (MSM office use only)

Status: Student Program _____ _____Medical Student _____ Yr _____ Resident_____ Dept _____

PART II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (*All information must be in English)*

A. MMR (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after 1956.)

1. Dose #1 given at age 12 months or later. ..... ___/___/_____
M D Y
2. Dose #2 given at least 28 days after first dose..... ___/___/_____
M D Y

OR ***Copies of all Lab reports MUST be attached***

Measles antibody ___/___/_____ Result: Immune _____ Non-Immune _____
M D Y

Mumps antibody ___/___/_____ Result: Immune _____ Non-Immune _____
M D Y

Rubella antibody ___/___/_____ Result: Immune _____ Non-Immune _____
M D Y

B. VARICELLA *(Two doses required)* ***"History of Disease" IS NOT acceptable***

1. a. Dose #1 ..... ___/___/_____
M D Y

b. Dose #2 given at least 12 weeks after first dose ages 1-12 years. ..... ___/___/_____
and at least 4 weeks after first dose if age 13 years or older. M D Y

OR ***Copies of all Lab reports MUST be attached***

2. Varicella antibody ___/___/_____ Result: Immune _____ Non-Immune _____
M D Y

C. TETANUS, DIPHTHERIA, PERTUSSIS (*Tdap booster every ten years recommended for ages 11-64 unless contraindicated.*)

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 _____

D. HEPATITIS B *(Three doses required)*

1. Immunization (Hepatitis B)

a. Dose #1 ___/___/_____ b. Dose #2 ___/___/_____ c. Dose #3 ___/___/_____
M D Y M D Y M D Y

OR ***Copies of all Lab reports MUST be attached***

2. Hepatitis B surface antibody Date ___/___/_____ Result: Immune _____ Non-Immune _____
M D Y

E. Tuberculin Skin Test (PPD) *(Required annually of all medical students and any student who will have contact with patients during the academic year.)*

(PPD result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0".)

Date Given: ___/___/___ Date Read: ___/___/___
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

Chest X-ray (required if PPD skin test is positive. ***Please attach a copy of the report***. Normal_____ Abnormal _____
Date Read ___/_____/_____

Treatment: Have you been treated with INH drug therapy? Yes ___ No ___ From ___/ ___/ ____ TO ____/____/____
***If yes, complete TB screening Questionnaire**

Have you received the BCG Vaccine? Yes _____ No _____ Date ___/ ____/ ____

TB Screening Questionnaire
In the past 6 months have you experienced any of the following for greater than three weeks?

Excessive sweating at night	Yes ☐	No ☐
Excessive weight loss	Yes ☐	No ☐
Persistent coughing	Yes ☐	No ☐
Excessive Fatigue	Yes ☐	No ☐
Coughing up blood	Yes ☐	No ☐
Hoarseness	Yes ☐	No ☐
Persistent Fever	Yes ☐	No ☐

Additional Vaccines
You may have already received, but are NOT required for entrance to the MSM program. Please note that additional vaccines may be required by affiliate institutions for clinic rotations.

		Month	Date	Year
Hepatitis A Vaccine #1				
Hepatitis A Vaccine #2				
Meningitis				
Polio last booster				
Yellow Fever				
Typhoid	☐ oral ☐ injection			

Verification of the above Immunization Record by healthcare Provider:

_____ _____ Date: _____
Print Name of Healthcare Provider Signature of Healthcare Provider

PLEASE return this form via mail to:

Admissions – Student Affairs
Morehouse School of Medicine
720 Westview Dr.
Atlanta, Georgia 30310