AUCC Immunization Form
Student Health and Wellness Center
455 Lee St SW, Suite 300A, Atlanta, GA 30310
(404) - 756 - 1241
https://www.msm.edu/Current_Students/student-health/

Name: _____ **DOB**: ____/____/_____

Circle Your School: Clark Atlanta University Morehouse College Morehouse School of Medicine

Student ID: _____ **School Email**: _____ **Phone**: _____

Address: _____ **City**: _____ **State**: _____ **Zip Code**: _____

Instructions:

- This form **MUST** be completed by a healthcare provider and stamped by the office**. No exceptions**
- Retain a copy of the completed form for your records.
- Scan this QR code for instructions on how to access your portal and upload the information.
- Upload a copy of this completed form to your Point and Click Patient Portal.

REQUIRED IMMUNIZATIONS

Required Immunizations	Date Administered (MM/DD/YYYY)	Required For
MMR (Measles, Mumps, and Rubella)	1st Dose ___/___/_____ 2nd Dose ___/___/_____ **OR** attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	Students born in 1957 or later and all foreign-born students, regardless of year born. If a titer is performed and does not indicate immunity a subsequent injection series is required. Antibody titer report must be submitted on lab letter head from a certified laboratory.
Varicella (Chicken Pox)	1st Dose ___/___/_____ 2nd Dose ___/___/_____ **OR** attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	All U.S. born citizens born in 1980 or later and all foreign-born students regardless of year born. If a titer is performed and does not indicate immunity a subsequent injection series is required. Antibody titer report must be submitted on lab letter head from a certified laboratory.
TDAP	Received within the last 10 years ___/___/_____	One dose of TDAP received within the last 10 years.

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Hepatitis B (check box below) ❑ **2 dose series** ❑ **3 dose series** ❑ **Hep A – Hep B Twinrix**	Either 2 dose series or 3 dose series 1st Dose ___/____/_____ 2nd Dose ___/____/_____ 3rd Dose ___/____/_____ **OR** attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	If a titer is performed and does not indicate immunity a subsequent injection series is required. Antibody titer report must be submitted on lab letter head from a certified laboratory.
Meningococcal MCV4/ Meningococcal ACWY/ Meningococcal Conjugate	One dose received on or after your 16th birthday. ___/____/_____	For all students 21 years old or younger and any student living in the dormitories. If your last dose was received >5 years ago, a booster dose is recommended. Please discuss with your health care provider. ❑ I attest that I am a graduate student living off campus.
Meningococcal B (check box below) ❑ **2 dose series Bexsero** ❑ **2 dose series Trumenba**	2 dose series 1st Dose ___/____/_____ 2nd Dose ___/____/_____	Required for individuals living in dorms/apartments and those younger than 23 years of age. Recommended for graduate students living off campus. ❑ I attest that I am a graduate student living off campus.

Signature of Health Care Provider and Date Required

Name:
Signature:
Address:
Phone Number:
Date:

Office Stamp Required

Revised: 2/20/2025

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RECOMMENDED IMMUNIZATIONS

Recommended Vaccines	Date Administered (MM/DD/YYYY)	Recommended For
Hepatitis A (check box below) ❑ **2 dose series** ❑ **3 dose series**	Either 2 dose series or 3 dose series 1st Dose ___/____/_____ 2nd Dose ___/____/_____ 3rd Dose ___/____/_____	Recommended for individuals with chronic liver disease, HIV infection, men who have sex with men, injection drug use, those working with Hepatitis A virus, who travel to countries with high prevalence countries, pregnancy, and settings for exposure.
Influenza Annually	Dose from most recent season ___/____/_____	All individuals residing in dormitories or other group living situations, or who are members of athletic teams. Individuals with asthma, diabetes, or immunodeficiency.
Human Papillomavirus (check box below) ❑ **2 dose series** ❑ **3 dose series**	Either 2 dose series or 3 dose series 1st Dose ___/____/_____ 2nd Dose ___/____/_____ 3rd Dose ___/____/_____	Strongly recommended for all unvaccinated males and females through age 26.
COVID-19 (check box below) ❑ **Bivalent vaccine** ❑ **Updated Pfizer vaccine** ❑ **Updated Moderna Vaccine** ❑ **Novavax vaccine**	Either 1 dose series or 2 dose series 1st Dose____/____/_____ 2nd Dose____/____/_____	Strongly recommended for all persons aged ≥6 months to protect from severe disease, hospitalization, and death.

Signature of Health Care Provider and Date Required
Name: Signature: Address: Phone Number: Date: Office Stamp Required

Revised: 2/20/2025

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Name: _____

TUBERCULOSIS TESTING FORM

Tuberculosis testing is required for all students attending Clark Atlanta University, Morehouse College University, and students in clinical programs at Morehouse School of Medicine. Students in clinical programs at Morehouse School of Medicine **MUST** have an IGRA test or Chest X-ray. **There are no exemptions allowed for tuberculosis testing**.

A.	**TST (Tuberculin Skin Test)** **If the test result is positive, please complete section C.** TST **must** be completed no more than **twelve months** prior to the start of classes within the U.S or Canada Date placed: _____ Date Read: _____ Result: _____mm ☐ Positive ☐ Negative A PPD/TST of ≥ 5 mm induration is considered positive for immunosuppressed students. A PPD/TST of ≥ 10 mm induration is considered positive for individuals with risk of exposure to TB. A PPD/TST of ≥ 15 mm induration is considered positive for students with no risk factors.
B.	**IGRA (Interferon Gamma Release Assay) Blood Test – may be completed as an alternative to section A.** **If the test result is positive, please complete section C.** **Please attach lab report in English.** IGRA = Quantiferon or T-Spot. If indeterminate or borderline results are received, repeat the test, or perform a chest x-ray in the United States or Canada
C.	**Chest X-ray - only if section A or B is positive.** **Please attach x-ray report.** Chest x-ray must be completed in the US/Canada only and must be completed no more than twelve months prior to the start of classes.
D.	If you have a history of tuberculosis disease, please provide written documentation of treatment and clearance from your healthcare provider.

Signature of Health Care Provider and Date Required
Name: Signature: Address: Phone Number: Date: Office Stamp Required