

PLEASE NOTE

ALL GRADUATE STUDENTS who are three quarter time or full time students are required by Massachusetts State Law to provide immunization records or proof of immunity. The information provided must be in **English.**

Graduate Student Immunization Record

Brandeis University

Health Center
415 South Street MS 034
Waltham, MA 02454-9110

Telephone 781-736-3677
brandeis.edu/health

**FOR HEALTH SERVICES
USE ONLY**

ALLERGIES:

Date Received: _____
Measles: #1 ☐ #2 ☐
Mumps: ☐ Rubella: ☐
Tetanus: ☐
Hepatitis B: #1 ☐ #2 ☐ #3 ☐
Meningococcal: ☐
PPD risk: low ☐ high ☐
Results: neg ☐ pos ☐
CXR: _____ INH: _____
Varicella: disease ☐ vaccine ☐
Complete: ☐ Exemption: ☐

Name: _____
Surname Given Name Middle Initial

Gender: _____

Date of Birth: _____
Month Day Year

Sage ID #: _____
(If known)

Birthplace: _____
Country

Permanent Address: _____
Street

City State Country Postal Code

Home Telephone: _____ (_____) _____
Country Code if International Area Code

Cell Phone: (_____) _____

Email address: _____ -

Date entering Brandeis University: _____ Program: _____

Were you an Undergraduate at Brandeis? _____ If yes, what dates did you previously attend or year of graduation: _____

Emergency Contact:

Name:

Last First Relationship

Address:

Street City State Zip Country

Home Telephone : _____ (_____) _____ Business Telephone : _____ (_____) _____

Health Information

Name: _____ Date of Birth _____

Have you ever had Chicken Pox (Varicella)? Yes ☐ No ☐ Vaccine ☐

Hospitalizations, Major Illnesses, Major Injuries, Surgeries:

Medications (Include prescription, over the counter, and herbal medicines):

Allergies (Medication or Food):

GRADUATE STUDENT IMMUNIZATION RECORD

In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15c, and Department of Public Health Regulations 105 CMR 220, Brandeis University requires verification of immunity for all mandated immunizations.

Student's Name _____
Last First M.I. Date of Birth ____/____/____

I. MANDATORY IMMUNIZATIONS

Please record doses given only, NOT anticipated dates of next doses.

ALL DOCUMENTATION MUST BE VERIFIED BY A LICENSED HEALTH CARE PROVIDER

	Month	Day	Year
MMR (MEASLES, MUMPS, RUBELLA) 2 doses required			
<input type="checkbox"/> Dose 1 Immunized at or after 12 months of age	Dose 1	_____	_____
<input type="checkbox"/> Dose 2 Given at least one month after Dose 1	Dose 2	_____	_____

If unable to document Measles, Mumps and/or Rubella immunization dates, you must have antibody titers. This is a blood test to prove you are immune. **A copy of the lab report with the value in English is required.**

TETANUS-DIPHTHERIA	Immunization booster within the last 10 years	Date:	_____	_____	_____
OR	Tetanus, diphtheria, acellular pertussis (Tdap)	Date:	_____	_____	_____

HEPATITIS B VACCINE	Dose 1 _____	Dose 2 _____	Dose 3 _____
	Month Day Year	Month Day Year	Month Day Year

If unable to document Hepatitis B immunization dates, you must have an antibody titer (HBsAB).
A copy of the lab report with the value in English is required.

MENINGOCOCCAL VACCINE :	Menactra Date: _____	OR	Menveo Date: _____
	Month Day Year		Month Day Year
OR	Menomune (WITHIN THE PAST FIVE YEARS)		_____
			Month Day Year

PLEASE NOTE: Massachusetts state law permits students to decline the meningitis vaccine. The waiver form is online at
www.brandeis.edu/studentaffairs/health/forms/index.html

II. RECOMMENDED (NOT REQUIRED)

Varicella Vaccine	Dose 1 _____	Dose 2 _____	OR Date of Disease _____
	Month Day Year	Month Day Year	Month Year
Hepatitis A Vaccine	Dose 1 _____	Dose 2 _____	
	Month Day Year	Month Day Year	
HPV Vaccine	Dose 1 _____	Dose 2 _____	Dose 3 _____
	Month Day Year	Month Day Year	Month Day Year
Polio Vaccine	Dose 1 _____	Dose 2 _____	Dose 3 _____
	Month Year	Month Year	Month Year

Name _____ MD, NP, PA, DO (not a parent clinician) Date: _____

Signature _____ Telephone (____) _____

Brandeis University

TUBERCULOSIS RISK QUESTIONNAIRE

Must be completed by all students and returned with Health Report

Name: _____ Date of Birth: _____

Country of Birth: _____

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever had a positive tuberculosis skin test? (If yes go to Page 2) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. To the best of your knowledge, have you had close contact with anyone who was sick with Tuberculosis (TB)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Were you born in one of the countries listed below? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you traveled or lived for more than one month in any of the countries listed below? | <input type="checkbox"/> | <input type="checkbox"/> |

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)

* World Health Organization. Global Tuberculosis Control. WHO report 2008.

Afghanistan	Djibouti	Madagascar	Republic of Moldova
Algeria	Dominican Republic	Malawi	Romania
Angola	DPR Korea	Malaysia	Russian Federation
Argentina	DR Congo	Maldives	Rwanda
Armenia	Ecuador	Mali	Sao Tome and Principe
Azerbaijan	El Salvador	Marshall Islands	Saudi Arabia
Bahamas	Equatorial Guinea	Mauritania	Senegal
Bahrain	Eritrea	Mauritius	Seychelles
Bangladesh	Ethiopia	Mexico	Sierra Leone
Belarus	Gabon	Micronesia	Solomon Islands
Belize	Gambia	Mongolia	Somalia
Benin	Georgia	Morocco	South Africa
Bhutan	Ghana	Mozambique	Sri Lanka
Bolivia	Guam	Myanmar	Sudan
Bosnia & Herzegovina	Guatemala	Namibia	Suriname
Botswana	Guinea	Nauru	Swaziland
Brazil	Guinea-Bissau	Nepal	Taiwan
Brunei Darussalam	Guyana	Nicaragua	Tajikistan
Burkina Faso	Haiti	Niger	Thailand
Burundi	Honduras	Nigeria	Togo
Cambodia	India	Niue	Turkmenistan
Cameroon	Indonesia	Northern Mariana Islands	Tuvalu
Cape Verde	Iraq	Pakistan	Uganda
Central African Republic	Kazakhstan	Palau	Ukraine
Chad	Kenya	Papua New Guinea	UR Tanzania
China	Kiribati	Paraguay	Uzbekistan
China, Hong Kong SAR	Kyrgyzstan	Peru	Vanuatu
China, Macao SAR	Lao PDR	Philippines	Viet Nam
Colombia	Latvia	Poland	Wallis & Futuna
Comoros	Lesotho	Portugal	Yemen
Congo	Liberia	Qatar	Zambia
Cote d'Ivoire	Lithuania	Republic of Korea	Zimbabwe

HIGH RISK: If the answer to question 2, 3 or 4 is **YES**, Brandeis University requires that you have a tuberculin skin test (Mantoux test) to check for latent tuberculosis infection. **YOUR HEALTHCARE PROVIDER MUST COMPLETE THE FORM ON THE BACK OF THIS PAGE**

LOW RISK: If the answer to all of the above questions is **NO**, a tuberculin skin test is not required.

Brandeis University

Medical Evaluation for Latent Tuberculosis Infection

(To be completed and signed by a licensed healthcare provider)

Name: _____ Date of Birth: ____ / ____ / ____

PLEASE NOTE: If patient has had a **POSITIVE TUBERCULIN SKIN TEST** in the past, the test should not be repeated. Go to Section B below.

A. TUBERCULIN SKIN TEST (Mantoux)

Test must be read by a healthcare provider 48-72 hours after administration. If no induration, indicate "0 mm".

Result of multiple puncture tests, such as Tine or Mono-Vac, are NOT accepted.

Date administered: ____ / ____ / ____ Date test read: ____ / ____ / ____ Result ____ mm of induration.
Month Day Year Month Day Year

Interpretation of Tuberculin skin test	
RISK FACTOR	POSITIVE RESULT
Close contact with a case of tuberculosis	5 mm or more
Born to a country that has a high rate of tuberculosis	10 mm or more
Traveled or lived for a month or more in a country that has a high rate of Tuberculosis	10 mm or more
No risk factors (test not recommended)	15 mm or more

B. If Tuberculin Skin Test is POSITIVE, now or by history, the following are required:

1. Date of positive PPD: Date: ____ / ____ / ____
Month Day Year

2. Chest X-ray: Required (attach report, NOT the X-ray) Date: ____ / ____ / ____
Month Day Year

☐ Normal ☐ Abnormal _____ (Describe)

3. Clinical Evaluation:

☐ Normal ☐ Abnormal _____ (Describe)

4. Treatment:

☐ No ☐ Yes _____ (Drug, dose, frequency and dates)

REQUIRED

PROVIDER SIGNATURE: _____ DATE: ____ / ____ / ____

HEALTHCARE

Month Day Year

Phone: _____ Fax: _____