Duke University Immunization Requirements for Graduate Students

North Carolina General Statute §130A 152-157 requires that ALL students entering college present a certificate of immunization which documents that the student has received the immunizations required by law. In addition to the state required immunizations, to promote the health of our students and to minimize the potential for transmission of communicable diseases within our community, immunization requirements differ for Health Science and Undergraduate students. For additional information review the immunization compliance section of our website at http://studentaffairs.duke.edu/studenthealth/immunization-compliance OR http://www.immunize.nc.gov/schools/collegesuniversities.htm

The general deadline for submission of the Mandatory Immunization Requirements Form, TB Screening Questionnaire and online Health History Forms is June 15th for the Fall Semester and December 15 for the Spring Semester. Students will be WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if the Mandatory Immunization and TB requirements have not been met.

All incoming students must be screened for Tuberculosis risk factors through a screening questionnaire. If TB testing is indicated by this questionnaire, a Tuberculosis skin test (TST) or IGRA (TB blood test) must be completed within the 6 months preceding the 1st day of classes. ALL TESTING (CXR/TST/IGRA) MUST BE COMPLETED IN THE UNITED STATES. TESTING DONE OUTSIDE OF THE UNITED STATES WILL NOT BE ACCEPTED! BCG vaccination does not prevent testing. For students who have received the BCG vaccine, an IGRA, either QuantiFERON TB Gold (QFT-G) or T-Spot, is preferred. If TST or IGRA is positive, a chest x-ray is required within the 12 months preceding the 1st day of classes.

If you cannot provide the results of a TB screening test, do not have a current TB screening test (within the 6 months prior to admission), or if your current test was not done in a United States facility, please call 1.919.681.9355 to schedule an appointment at Duke Student Health Services (SHS). If a student has recently received a live virus vaccine, TB testing should be delayed for 4 weeks. You must be enrolled in an acceptable insurance plan to have insurance coverage. Otherwise, please wait until you have insurance coverage.

International Students: If you are coming from a high-incidence TB area, testing must be done at Duke SHS. DO NOT WAIT! Late, incomplete or inaccurate information may delay registration.

Please read these instructions carefully! Your information will be reviewed by SHS staff. Immunization records are processed in order of receipt. You will be notified of compliance via secure message or if additional information is needed.

The following 4 steps are MANDATORY:

Step 1: Have a doctor’s office, clinic or health department complete the Mandatory Immunization Requirements Form
Step 2: Complete the Mandatory Tuberculosis Screening Questionnaire
Step 3: Log into the SHS portal (red heart entitled) “Student Health Gateway” http://studentaffairs.duke.edu/studenthealth using your Net ID and password, verify your identity by entering your date of birth, then Click the “Forms” tab on the left menu bar and complete the following online forms:

☐ Duke University HIPAA Agreement and Consent to Treat
☐ Health History Form
☐ Immunizations Page in EMF Forms

Step 4: Submit the completed Mandatory Immunization Requirements Form and TB Screening Questionnaire via:

Email: immunizations@duke.edu (Preferred Method) or Fax: 1.919.681.7386 or

Postal Mail: Duke Student Health Services
Attn: Immunization Department
DUMC 2899, Durham, NC 27710

IMPORTANT! You MUST enter your Immunization and TB history online via the STUDENT HEALTH GATEWAY before you fax or mail your completed forms. PLEASE KEEP A COPY OF YOUR IMMUNIZATION RECORDS! Should anything be amiss, you can easily refer to what was sent to SHS!

It may take up to 30 days for Duke SHS staff to verify your information.
# Duke University Mandatory Immunization Requirement Form for Graduate Students

**2018-2019**

<table>
<thead>
<tr>
<th>Last Name: ____________________________________________</th>
<th>First Name: ____________________________________________</th>
<th>MI: ____________________________</th>
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</thead>
<tbody>
<tr>
<td>Duke Unique ID: _____________________________</td>
<td>Date of Birth: <em><strong><strong>/</strong></strong></em>/_______</td>
<td>Sex: ____________________________</td>
</tr>
<tr>
<td>Have you previously attended Duke University? _________</td>
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</tbody>
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## SECTION A: REQUIRED IMMUNIZATIONS

**FORMS ARE DUE: JUNE 15 for fall admission, December 15 for spring admission. INFORMATION MUST BE IN ENGLISH.**

<table>
<thead>
<tr>
<th>Immunization Name</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
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<tbody>
<tr>
<td>DTaP/DTP/Td (All students must submit documentation of 3 doses of tetanus. One MUST be a Tdap. One must be given in the last 10 years.)</td>
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<tr>
<td>Tdap</td>
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<tr>
<td>MMR (Measles, Mumps, Rubella 2 MMR vaccines required on or after first birthday OR positive titers (lab reports must be attached.) OR</td>
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<tr>
<td>Measles (single antigen 2 required on or after first birthday)</td>
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<tr>
<td>Mumps (single antigen 2 required on or after first birthday)</td>
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<tr>
<td>Rubella (single antigen 1 required on or after first birthday)</td>
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### Hepatitis B (ONLY required if born on or after July 1, 1994. The State of NC does not accept titers for this requirement.)

- Engerix-B (3 doses required) OR
- Heplisav-B (2 doses required)

**TB Screening Questionnaire** Must be completed, signed and attached. Have you attached yours?

Yes       No

**Read form completely to determine if TB testing is required.**

## SECTION B: ADDITIONAL IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Immunization Name</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
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<tbody>
<tr>
<td>Meningococcal ACWY</td>
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<tr>
<td>Meningococcal B</td>
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<tr>
<td>Bexsero</td>
<td>OR</td>
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<tr>
<td>Trumenba</td>
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<tr>
<td>Gardasil</td>
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<tr>
<td>Twinrix (Hepatitis A/B)</td>
<td></td>
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<tr>
<td>Hepatitis A</td>
<td></td>
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<tr>
<td>Varicella (Chickenpox)</td>
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<tr>
<td>Polio</td>
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<tr>
<td>Rabies</td>
<td></td>
<td></td>
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<tr>
<td>Ixiaro (Japanese Encephalitis)</td>
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<tr>
<td>Typhoid (Specify vaccine)</td>
<td>Oral</td>
<td>IM</td>
<td></td>
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<tr>
<td>Yellow Fever</td>
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</tbody>
</table>

Provider Name (print) ____________________________________________ | Title ____________________________ | Date ____________________________ |

Provider Signature ____________________________ | Office Phone # ____________________________ |

Address/Official Stamp ____________________________________________

**Official stamp with authorized signature from MD, DO, PA, NP, RN or LPN required.**

**DUKE DOES NOT ACCEPT FORMS SIGNED BY FAMILY MEMBERS**

**Email to: immunizations@duke.edu (preferred method)**

**Fax to: 919-681-7386**

**Mail to: Duke Student Health Services, Attention: Immunization Department, DUMC Box 2899, Durham, NC 27710**

**IMPORTANT! KEEP A COPY OF THIS PAGE AND ALL LAB/ CHEST X-RAY REPORTS FOR YOUR RECORDS.**
# Duke University Mandatory Tuberculosis Screening Questionnaire for Graduate Students

**2018-2019**

### Last Name: ____________________________  First Name: ____________________________  Middle Initial: ________

**Duke Unique ID:** ____________________________

**Date of Birth:** ______/_____/______  **Sex:** ______

**SECTION A:** Have you ever had a positive (TST/PPD) or positive TB Blood Test (IGRA)?

- [ ] YES  [ ] NO

**SECTION B:** Tuberculosis (TB) Exposure Risk **

1. Do any of the following conditions or situations apply to you?

   - [ ] a. Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite or weight loss?  [ ] YES  [ ] NO
   - [ ] b. Have you ever lived with or been in close contact with a person known or suspected of having TB?  [ ] YES  [ ] NO
   - [ ] c. Have you ever lived, worked or volunteered in any homeless shelter, prison/jail or healthcare facility?  [ ] YES  [ ] NO
   - [ ] d. Have you ever used recreational IV Drugs?  [ ] YES  [ ] NO
   - [ ] e. Were you born in any of the countries listed below?  [ ] YES  [ ] NO
   - [ ] f. Have you lived, worked or traveled to one of the countries listed below for > 1 month (cumulative travel time)?  [ ] YES  [ ] NO
   - [ ] g. If yes, please circle below. Total length of time: __________

   **Afghanistan, Algeria, Angola, Anuquilla, 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, Congo, 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, Sao Tome and Principe, Senegal, Serbia, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Taiwan, Tajikistan, Tanzania (United Republic of), Thailand, Timor-Leste, Togo, Tunisia, Turkmenistan, Tuvalu, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe**

   Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015 Countries with incidence of ≥ 20 cases per 100,000 population.

- [ ] d. Have you ever received the BCG vaccine?  [ ] YES  [ ] NO

*If you answered YES to Section A, you will need to sign below and submit this form along with 1. a chest x-ray report (X-ray must be done in the US within the past 12 months), and 2. documentation from a clinician indicating acceptance or declination of latent/active TB treatment. If you have not had a chest x-ray you must have one when you arrive at Duke University.

**SECTION C:** Bacille Calmette-Guérin History

Have you ever received the BCG vaccine?  [ ] YES  [ ] NO

*If you answered YES to any of the questions in Section B, Duke SHS requires that TB testing (TST or IGRA) be done within the 6 months preceding the first day of classes. TB testing must be done in the US. If you received the BCG Vaccine, a TB blood test (IGRA) is the preferred method of testing.

**Student Signature:** ____________________________  **Date:** ______/_____/______

### SECTION D: If you answered YES to any questions in Section B, THIS SECTION MUST BE COMPLETED AND SIGNED by a doctor’s office, clinic or health department. We do not accept forms signed by family members. ALL TESTING (X/R/TST/IGRA) MUST BE COMPLETED IN THE UNITED STATES WITHIN 6 MONTHS PRECEDING THE FIRST DAY OF CLASSES! IGRA (either Quantiferon (QFT-G) or T-Spot) is the preferred method of testing for students with history of receiving the BCG vaccine. If a student has recently received any live virus vaccine, TB screening should be delayed for 4 weeks.

**Tuberculin Skin Test:** Date placed: ______/_____/______  Date read: ______/_____/______  # of mm induration ________  mm interpretation __________

OR

**IGRA (Quantiferon (QFT-G) or T-Spot): MUST ATTACH IGRA LAB REPORT**

**Date of Chest X-ray (CXR): ______/_____/______  MUST ATTACH RADIOLOGY REPORT**

**Provider Name (print): ____________________________  **Title:** ____________________________  **Office Phone #:** ____________________________

**Provider Signature:** ____________________________  **Date:** ______/_____/______

**Email to immunizations@duke.edu (preferred), Fax to 1.919.681.7386, or Mail to Duke Student Health Services, DUMC Box 2899, Durham, NC 27710**

**IMPORTANT: KEEP A COPY OF THIS PAGE AND ALL LAB/CHEST X-RAY REPORTS FOR YOUR RECORDS.**