Duke University Mandatory Immunization Requirements for Health Science 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 Students. For additional information review the immunization compliance section of our website at http://studentaffairs.duke.edu/studenthealth/immunization-compliance.

The general deadline for submission of the Mandatory Immunization Requirements Form, TB Screening Questionnaire and online Health History Forms is June 15th for fall semester and December 15th for spring semester. Individual programs may have different immunization deadlines. Students will be WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if the Mandatory Immunization and TB requirements have not been met.

The following immunizations are required for Health Science Students:

- **Hepatitis B -** 3 dose series AND a positive Hepatitis B surface Antibody (HBsAb) quantitative titer. Ideally the titer is done 2 months after the third vaccine. If the quantitative titer is negative, another 3 dose hepatitis B series must be completed followed by a repeat titer. 
  
  ***NOTE: All titers must include a lab report.***

- **Tetanus/Diphtheria/Pertussis -** Tetanus/Diphtheria toxoid (DT/DTaP/DTP/Td) 2 doses and a Tdap REQUIRED: 3 total doses are required, one dose must be given within the past 10 years.

- **Measles/Mumps/Rubella -** Two measles (rubeola), two mumps, one rubella OR positive titers. If student is unable to document 2 measles, 2 mumps and 1 rubella we will accept a positive MMR titer. If titer is negative or inconclusive/equivocal then start MMR vaccine 2 dose series (dose # 2 must be given a minimum of 28 days after dose # 1) If student HAS proof of 2 measles, 2 mumps and 1 rubella and titer is negative or inconclusive/equivocal, 1 booster dose of MMR is required.

- **Varicella -** 2 doses of varicella-containing vaccine given on or after 12 months of age and at least 28 days apart OR positive Varicella IgG titer. Students with one prior dose of vaccine, or with a negative antibody titer should receive a total of two doses of vaccine. 
  
  ***NOTE: All titers must include a lab report.***

- **Tuberculosis skin test (TST) or IGRA (TB blood test) -** Must be completed within 6 months preceding the 1st day of classes. 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 a student has recently received a live virus vaccine, TB testing should be delayed for 4 weeks.

- **Influenza -** Duke requires that all healthcare personnel receive the influenza vaccine annually.

**IMPORTANT! Student Health Services (SHS) DOES NOT ACCEPT TB TESTING OR CHEST X-RAYS DONE OUTSIDE OF THE U.S.** If you need TB testing please call 1.919.681.9355, once you arrive at Duke, to schedule an appointment.

**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, via secure message through your Duke email, of compliance or if additional information is needed.

**The following 3 steps are MANDATORY:**

**Step 1:** Have a doctor’s office, clinic or health department complete the Mandatory Immunization Requirements Form including the TB Screening Questionnaire

**Step 2:** Log into the SHS portal (red ❤ 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 Form

**Step 3:** 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: Immunizations Department
DUMC 2899, Durham, NC 27710

**IMPORTANT! You MUST enter your Immunization and TB history online via the STUDENT HEALTH GATEWAY before you send your completed forms. PLEASE KEEP A COPY OF YOUR IMMUNIZATION RECORDS!**

**It may take up to 30 days for Duke SHS staff to verify your information.**
Duke University Mandatory Immunization Requirement Form for Health Science Students 2018-2019

Last Name: ____________________________  First Name: ____________________________  MI: __________
Duke Unique ID: ____________________________  Date of Birth: ___/___/_______  Sex: ________

Have you previously attended Duke University? ________

SECTION A: REQUIRED 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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</thead>
<tbody>
<tr>
<td>DTaP/DTP/Td</td>
<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</td>
<td>(Measles, Mumps, Rubella. 2 MMR vaccines required on or after first birthday OR positive titers - lab report must be attached)</td>
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<tr>
<td>Measles</td>
<td>(single antigen 2 required on or after first birthday)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mumps</td>
<td>(single antigen 2 required on or after first birthday)</td>
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<td></td>
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<tr>
<td>Rubella</td>
<td>(single antigen 1 required on or after first birthday)</td>
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<td></td>
<td></td>
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<tr>
<td>Hepatitis B</td>
<td>(3 doses required if born on or after 7/1/94)</td>
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<tr>
<td>Engerix-B</td>
<td>(3 doses required) OR</td>
<td></td>
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<tr>
<td>Heplisav-B</td>
<td>(2 doses required)</td>
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<tr>
<td>Hepatitis B Titer</td>
<td>(must attach lab report)</td>
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<tr>
<td>Hepatitis B -2nd series (if required)</td>
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<tr>
<td>Engerix-B</td>
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<tr>
<td>Heplisav-B</td>
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<tr>
<td>Hepatitis B Titer</td>
<td>(#2 if required) - must attach lab report</td>
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<tr>
<td>Varicella</td>
<td>(2 dose series or positive titer - lab report must be attached)</td>
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<tr>
<td>Seasonal Influenza</td>
<td>(required for spring entrance)</td>
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<tr>
<td>TB Screening Questionnaire and testing</td>
<td><strong>Is yours completed, signed, and attached?</strong> Yes No</td>
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</tr>
</tbody>
</table>

SECTION B: RECOMMENDED 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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</thead>
<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 combination)</td>
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<tr>
<td>Hepatitis A</td>
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<tr>
<td>Polio</td>
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<td>Ixiaro (Japanese Encephalitis)</td>
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<tr>
<td>Yellow Fever</td>
<td>Oral</td>
<td>IM</td>
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<tr>
<td>Typhoid (specify vaccine)</td>
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<tr>
<td>Rabies</td>
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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.
**SECTION A:** Have you ever had a positive (TST/PPD) or positive TB Blood Test (IGRA)?

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**YES ☐ NO ☐**

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**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 being sick with active 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 ever lived 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? _________________

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

Have you ever received the BCG vaccine? YES ☐ NO ☐

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*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, (CXR 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.

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Student Signature: __________________________________________ Date ________________

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**SECTION D:** 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 (CXR/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, screening for TB should be delayed for 4 weeks.

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**Tuberculin Skin Test:** Date placed: __/__/____ Date read: __/__/____ # of mm induration _______ interpretation__________

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**OR**

**IGRA (QuantiFERON (QFT-G) or T-Spot)** Date: __/__/____ Result: ______________ MUST ATTACH IGRA LAB REPORT

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

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Provider Name (print): __________________________ Title: ______________ Office Phone #: __________________

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Provider Signature: __________________________ Date: ______________

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**Email to immunizations@duke.edu (preferred), Fax to 919.681.7386, or Mail to Duke Student Health Services, DUMC Box 2899, Durham, NC 27710**

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