Duke University Immunization Requirements for Undergraduate/Graduate/Professional 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.

The general deadline for submission of the Mandatory Immunization Requirements Form, TB Screening Questionnaire and online Health History Forms is June 15th. Students will be WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if the Mandatory Immunization and TB requirements have not been met.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 12 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 12 months), 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) after August 1. If a student has recently received any live virus vaccine, screening for TB should be delayed for 4 weeks. 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 and may take up to 4 weeks for processing. You will be notified of your compliance status via secure message. (Please be sure to monitor your Duke email.)

If student is less than 18 years old at the start of classes, a parent/ guardian must complete, sign and return the Consent for Treatment form. https://studentaffairs.duke.edu/sites/default/files/u110/CONSENT%20FOR%20TREATMENT%202016.pdf

The following 4 steps are MANDATORY:

Step 1: Have a doctor’s office, clinic or health department complete the Mandatory Immunization Requirements Form. We are unable to accept signatures from family members, by blood or marriage.

Step 2: Complete the Mandatory Tuberculosis Screening Questionnaire

Step 3: Follow this link http://studentaffairs.duke.edu/studenthealth (click on gray 🎯). Log in by entering your Net ID and password, verify your identity by entering your date of birth, click on 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, TB Screening Questionnaire and Consent for Treatment form if needed (if less than 18 years old) via:

   Email: immunizations@duke.edu
   OR
   Fax: 1.919.681.7386
   OR
   Postal Mail: Duke Student Health Services
   ATTN: Immunization Department
   DUMC Box 2899, Durham, NC 27710

IMPORTANT! You MUST enter your Immunization dates via the STUDENT HEALTH GATEWAY before you fax or email 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 Requirements Form for Undergraduate/Graduate/Professional Students

Last Name_________________________________________ First Name ______________________________________ Middle Initial ______

Duke Unique ID ____________________________________________ Date of Birth ________/______/_______ Sex ________

**DO NOT SEND IMMUNIZATION RECORDS; USE THIS FORM ONLY!**

Forms must be in ENGLISH ONLY

Form MUST BE COMPLETED AND SIGNED by a doctor’s office, clinic or health department, NOT a family member.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Requirement</th>
<th>Dose Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus/diphtheria toxoid (DT/DTaP/DTP/Td)</td>
<td>2 doses and a Tdap Booster REQUIRED FOR ALL:</td>
<td>3 total lifetime doses are required, this is a State of NC law; one dose must be given within the past 10 years. Td is a different vaccine and does not substitute for Tdap. Tdap became available in the U.S. June 2005.</td>
</tr>
<tr>
<td>DTaP/ DTP/ DT/ Td</td>
<td></td>
<td><strong><strong>/</strong></strong>/____ , <strong><strong>/</strong></strong>/<strong><strong>, <strong><strong>/</strong></strong>/</strong></strong>, <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Tdap booster REQUIRED (Boostrix or Adacel)</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>MMR (Measles, Mumps, Rubella)</td>
<td>2 doses REQUIRED FOR ALL:</td>
<td>Both doses must be given at least 28 days apart and after 12 months of age. If given as single antigen vaccine, you must have 2 Measles (Rubeola), 2 Mumps and 1 Rubella (German Measles) OR positive MMR IgG antibody titer (laboratory report must be attached). Vaccine doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated.</td>
</tr>
<tr>
<td>MMR #1</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>MMR #2</td>
<td></td>
<td><strong><strong>/</strong></strong>/<strong><strong>, <strong><strong>/</strong></strong>/</strong></strong></td>
</tr>
<tr>
<td>OR list single antigen vaccines</td>
<td></td>
<td>below</td>
</tr>
<tr>
<td>Measles #1</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Measles #2</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Mumps #1</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Mumps #2</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Rubella #1</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Polio</td>
<td>3 doses REQUIRED FOR STUDENTS &lt; AGE 18:</td>
<td>#1 <strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong>, #3 <strong><strong>/</strong></strong>/<strong><strong>, #4 <strong><strong>/</strong></strong>/</strong></strong></td>
</tr>
<tr>
<td>Hepatitis B Series</td>
<td>3 doses REQUIRED IF BORN ON OR AFTER 7/1/1994:</td>
<td>Given as a series with 4 weeks between the first and second doses, 8 weeks between the second and third doses and at least 16 weeks between the first and third doses. Vaccine doses administered at less than the minimum intervals are not valid and must be repeated. Indicate vaccine type:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Hep B only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Hep A/B Combo (Twinrix)</td>
</tr>
<tr>
<td>Meningococcal vaccine</td>
<td>REQUIRED FOR UNDERGRADUATES: Booster dose is required if the initial dose was given before the age of 16. If the initial dose was given at age 16 or older, no booster dose is required. Not required for graduate/professional students.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GIVEN ON OR AFTER AGE 16</td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Recommended Vaccines (not required):</td>
<td></td>
<td>Varicella Vaccine #1 <strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong>  Chickenpox Illness <strong><strong>/</strong></strong>/____  Pneumococcal Vaccine <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Meningitis B Vaccines</td>
<td>Trumenba #1 <strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong>, #3 <strong><strong>/</strong></strong>/____ or Bexsero #1 <strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong></td>
<td></td>
</tr>
<tr>
<td>HPV 4 or 9 #1</td>
<td><strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong>, #3 <strong><strong>/</strong></strong>/____  Cervarix #1 <strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong>, #3 <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>Travel Vaccines (not required):</td>
<td></td>
<td>Hepatitis A #1 <strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong>  Yellow Fever <strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Rabies #1</td>
<td><strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong>, #3 <strong><strong>/</strong></strong>/<strong><strong>, #4 <strong><strong>/</strong></strong>/</strong></strong>  Polio Booster <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td>IXIARO #1</td>
<td><strong><strong>/</strong></strong>/<strong><strong>, #2 <strong><strong>/</strong></strong>/</strong></strong>, #3 <strong><strong>/</strong></strong>/<strong><strong>, #4 <strong><strong>/</strong></strong>/</strong></strong>  Typhoid (IM) <strong><strong>/</strong></strong>/____  Typhoid (Oral) <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
</tbody>
</table>

Official stamp with authorized signature from a MD, DO, PA, NP, RN or LPN must appear on this form or it will not be accepted.

Provider Name (print):______________________________ Title:________________________ Phone #:________________________

Provider Signature:__________________________________________ Date:__________/______/_______

Address/Official Stamp Here: ____________________________________________________________

E-mail, Fax or Mail to: Duke Student Health Services, Attention: Immunization Department, DUMC Box 2899, Durham, NC 27710
Fax to 1.919.681.7386 Email to immunizations@duke.edu

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

Last Name: _____________________________ First Name: _____________________________ Middle Initial: _____________________________

Duke Unique ID: _____________________________ Date of Birth: __/__/____ Sex: _____________________________

ALL Students must complete Sections A & B, sign and submit this form, regardless if testing has been completed or will be done once you arrive.

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

YES ☐ NO ☐

If you answered YES, you will need to sign below and submit this form along with a chest x-ray report. If you have not had a chest x-ray you must have one when you arrive at Duke University. If you answered NO, please continue to Sections B and C.

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 to a person known or suspected of being sick with TB? YES ☐ NO ☐
   c. Have you ever worked, volunteered or been 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 or have you lived, worked or traveled to one of the following countries listed in the boxes below for > 1 month (cumulative travel time)? YES ☐ NO ☐

2. If yes, where? _________________________________________ Total length of time? ___________________________

SECTION C: Bacille Calmette-Guérin History

1. Have you ever received the BCG vaccine? YES ☐ NO ☐
   a. If you answered yes to any questions in Section B and C, then a TB blood test (IGRA) is the preferred method of testing.
   b. If you have received the BCG vaccine and all other answers are No, no further screening is required. Please sign and submit this form.

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 12 months preceding the first day of classes: SEE SECTION D

Student Signature: _____________________________ Date: _____________________________

SECTION D: MUST BE COMPLETED AND SIGNED by a doctor’s office, clinic or health department. ALL TESTING (CXR/TST/IGRA) MUST BE COMPLETED IN THE UNITED STATES WITHIN THE 12 MONTHS PRECEDING THE FIRST DAY OF CLASSES! Students who have received the BCG vaccine, an IGRA, (either QuantiFERON® (QFT-G) or T-Spot.) is preferred. If a student has recently received any live virus vaccine, screening for TB should be delayed for 4 weeks. Please refer to section A if you have, or have had a positive TST or IGRA.

Tuberculin Skin Test Date placed: __/__/____ Date read: __/__/____ # of mm induration (recorded as actual millimeters) _______ mm OR QFT-G Date: __/__/____ Result: ___________ OR T-Spot Date: __/__/____ Result: ___________ (MUST ATTACH IGRA LAB REPORT)

Date of Chest x-ray (CXR): __/__/____ Result: ___________ (MUST ATTACH RADIOLOGY REPORT)

Provider Name (print): _____________________________ Title: _____________________________ Office Phone #: _____________________________

Provider Signature: _____________________________ Date: __/__/____

Email, Fax or Mail to: Duke Student Health Services, Attention: Immunization Department, DUMC Box 2899, Durham, NC 27710
Fax to 919.681.7386 Email to immunizations@duke.edu

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