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 Students will be WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if the Mandatory Immunization and TB requirements have not been met.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). 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 (Duke performs targeted TB testing)

**Step 3:** 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 Forms

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

- **Email:** immunizationrecords@dm.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 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 Requirements Form for Undergraduate/Graduate/Professional Students

Last Name: ___________________________ First Name: ___________________________ Middle Initial: ________

Duke Unique ID: ___________________________ Date of Birth: _____ / _____ / _______ Sex: ______

FORM IS DUE JUNE 15 AND MUST BE COMPLETED AND SIGNED BY A DOCTOR’S OFFICE, CLINIC, OR HEALTH DEPARTMENT

Keep a copy for your records Information must be in English and in MM/DD/YYYY format

**Tetanus/diphtheria toxoid (DT/DTaP/DTP/Td) 2 doses and a Tdap Booster REQUIRED:** 3 total doses are required; one dose must be given within the past 10 years. Td is a different vaccine, and does not substitute for Tdap which became available in the U.S. June 2005. Titers are NOT accepted in lieu of vaccine.

DTaP/ DTP/ DT/ Td #1 _____/_____/____, #2 _____/_____/____, #3 _____/_____/____ Tdap booster REQUIRED _____/_____/____

**MMR (Measles, Mumps, and Rubella) 2 doses REQUIRED:** 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, 2 Mumps and 1 Rubella OR positive MMR IgG antibody titer (LAB 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.

MMR #1 _____/_____/____ MMR #2 _____/_____/____ OR list single antigen vaccines below:

Measles #1 _____/_____/____, Measles #2 _____/_____/____, Mumps #1 _____/_____/____, Mumps #2 _____/_____/____, Rubella #1 _____/_____/____

**Hepatitis B 3 doses REQUIRED:** 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. Optional two-dose schedule of Recombivax HB® only for vaccination of adolescents 11-15 years of age. Vaccine doses administered at less than the minimum intervals are not valid and must be repeated.

#1 _____/_____/____, #2 _____/_____/____, #3 _____/_____/____ OR (two-dose schedule 11-15 years of age) #1 _____/_____/____, #2 _____/_____/____

OR given as Twinrix (Hep A/B Combo) #1 _____/_____/____, #2 _____/_____/____, #3 _____/_____/____

**Meningitis (MCV4) Booster REQUIRED:** Booster dose must be given to first-year college students if the previous dose was given before the age of 16. If the initial dose was given at age 16 or older, no booster dose is required. #1 _____/_____/____ Booster dose _____/_____/____

(not required) Bexsero #1 _____/_____/____, #2 _____/_____/____ OR Trumenba #1 _____/_____/____, #2 _____/_____/____, #3 _____/_____/____

**Polio 4 doses REQUIRED if under age 18:** #1 _____/_____/____, #2 _____/_____/____, #3 _____/_____/____, #4 _____/_____/____

**Recommended (not required):** Varicella Vaccine #1 _____/_____/____, #2 _____/_____/____ OR Chickenpox Illness _____/_____/____

Gardasil #1 _____/_____/____, #2 _____/_____/____, #3 _____/_____/____ OR Cervarix #1 _____/_____/____, #2 _____/_____/____, #3 _____/_____/____

**Travel Vaccines (not required):** Hepatitis A #1 _____/_____/____, #2 _____/_____/____ Yellow Fever _____/_____/____

Rabies #1 _____/_____/____, #2 _____/_____/____, #3 _____/_____/____, #4 _____/_____/____

Ixiaro #1 _____/_____/____, #2 _____/_____/____ Typhoid (IM) _____/_____/____ Typhoid (Oral) _____/_____/____

An official stamp from a doctor’s office, clinic or health department AND an authorized signature from a MD, DO, PA, NP, RN or LPN must appear on this form or it will not be accepted. Mail, fax or email completed forms to: Duke University Student Health Center, Attention: Immunization Department, DUMC Box 2899, Durham, NC 27710 OR Fax to 1.919.681.7386 Email to immunizationrecords@studentaffairs.duke.edu

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

Provider Signature: ___________________________ Date: _____ / _____ / _______

Address/Official Stamp Here:

IMPORTANT! KEEP A COPY OF THIS PAGE AND ALL LAB REPORTS FOR YOUR RECORDS.
Duke University Mandatory Immunization Requirements Form for Undergraduate/Graduate/Professional Students

Last Name: __________________________ First Name: __________________________ Middle Initial: ______

Duke Unique ID: ______________________ Date of Birth: ______/_____/______ Sex: ______

TB testing must be completed in the U.S. Within the 12 months preceding the 1st day of classes. ALL Students: You must complete Sections A and B and submit form along with the mandatory immunization requirements form. International Students: Section C will be completed at Duke Student Health Services once you arrive.

SECTION A: 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 lived, worked or volunteered in any homeless shelter, prison/jail or healthcare facility? YES ☐ NO ☐

2. Were you born in, or have you lived, worked or traveled to one or more of the following countries listed in the box below for >1 month? If yes, Where? ____________________________________________________________ How long? __________________________

   Afghanistan, Albania, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Cabo Verde, Cambodia, Cameroon, Chad, China, Colombia, Comoros, Congo, Cote D’Ivoire, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Gabon, Gambia, Ghana, Guatemala, Guam, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Hungary, India, Indonesia, Iran (Islamic Republic of), Iraq, Japan, 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, Nicaragua, Niger, Niue, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent and the Grenadines, Sao Tome and Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Tajikistan, Taiwan, Tanzania, Thailand, Timor-Leste, Togo, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Vietnam, Yemen, Zambia, Zimbabwe.

3. Have you ever had a positive Tuberculin Skin Test (TST/PPD) OR positive TB blood test (IGRA)? YES ☐ NO ☐
   • If you had a positive Tuberculin Skin Test or positive TB blood test, have you had a chest x-ray in the past 12 months? YES ☐ NO ☐
   • Have you had treatment for latent TB? YES ☐ NO ☐ If yes, please list start date ______/_____/______ end date ______/_____/______

Section B: Bacille Calmette-Guerin History: Have you ever received the BCG vaccine? YES ☐ NO ☐

If yes, TB blood test IGRA is the preferred method of testing.

Student Signature: __________________________ Date __________________

SECTION C: Must be completed by a MD, DO, PA, NP, RN or LPN. ALL TESTING (CXR/TST/IGRA) MUST BE COMPLETED IN THE U.S. 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 a live virus vaccine, TB testing should be delayed for 4 weeks. If TST or IGRA is positive, a Chest x-ray is REQUIRED. Anyone with a positive TST or IGRA with no signs of active disease on chest x-ray should receive recommendation to be treated for latent TB.

Tuberculin Skin Test Date placed: ______/_____/_____ Date read: ______/_____/_____ Results: ______ # of mm induration OR

QFT-G Date: ______/_____/_____ OR T-Spot Date: ______/_____/_____ (MUST ATTACH FULL LAB REPORT)

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

Provider Name (print): __________________________ Title: _______ Phone #: ______

Provider Signature: __________________________ Date: ______/_____/______

Address/Official Stamp Here: __________________________

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

Fax to 1.919.681.7386 Email to immunizationrecords@studentaffairs.duke.edu

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