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 Students will be WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if the Mandatory Immunization and TB requirements have not been met.

To help promote the health of our Health Science Students and to minimize the potential for transmission of communicable diseases for the students, their patients, and their contacts, we require the following immunizations:

- **Hepatitis B** 3 dose series AND a positive Hepatitis B surface Antibody (HBsAb) quantitative titer (greater than 10 mIU/ml). Ideally the titer is done 2 months after the third vaccine. If the quantitative titer is less than 10 mIU/ml, another 3 dose hepatitis B series must be completed and a quantitative HBsAb be rechecked 2 months afterwards. **NOTE: All titers must include a lab report.**

- **Tetanus/Diphtheria/Pertussis**- 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.

- **Measles/Mumps/Rubella**- Two Measles (rubella), 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 1Rubella and titer is negative or inconclusive/equivocal, 1 booster dose of MMR is required.

- **Varicella**- History of Chicken Pox illness AND Positive IgG titer OR 2 doses of varicella-containing vaccine given on or after 12 months of age and at least 28 days apart AND Varicella IgG titer. Students without a history of disease, with one prior dose of vaccine, or with a negative antibody titer should receive a total of two doses of vaccine followed by a Varicella IgG titer 2 months after receiving the 2nd dose. If your varicella result is negative, make sure the correct titer was performed, IgG, not IgM. **NOTE: All titers must include a lab report.**

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

**IMPORTANT! Student Health Services (SHS) DOES NOT ACCEPT TB TESTING OR CHEST X-RAYS DONE OUTSIDE OF THE U.S.**

If you cannot provide the results of a TB test, do not have a current TB test (within the 12 months), or if your current test was not done in a United States facility please call 1.919.681.9355, once you arrive at Duke, to schedule an appointment at Duke 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. **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, via secure message through your Duke email, of compliance 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 Form

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

Fax: 1.919.681.7386 OR Email: immunizations@duke.edu

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 Requirements Form for Health Science Students**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Duke Unique ID:** ___________________________ **Date of Birth:** __________/________/________

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

**DTaP/ DTP/ DT/ Td** #1 __________/________/________, #2 __________/________, Tdap booster **REQUIRED** #3 __________/________

### MMR (Measles, Mumps, Rubella) **2 doses REQUIRED** Positive MMR IgG antibody titers are acceptable if proof of vaccination is not available. **(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.

<table>
<thead>
<tr>
<th>Measles #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
<th>MMR #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
<th>MMR #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
<th>OR list single antigen vaccines below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Mumps #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Mumps #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Rubella #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
</tr>
</tbody>
</table>

### Hepatitis B 3 dose series AND positive Hepatitis B surface antibody (HBsAb) quantitative titer **REQUIRED:** If the titer is not positive a second 3 dose Hepatitis B series must be completed. Then repeat the (HBsAb) titer 2 months after completion of the 2nd 3 dose series. Note – if the student does not have an adequate HBsAb after the second 3 dose series the student is considered a non-responder and further medical assessment and evaluation is indicated by a medical provider.

***NOTE: All titers must include a lab report.***

<table>
<thead>
<tr>
<th>Hepatitis B OR Hepatitis A/B combo (Twinrix)</th>
<th>Hepatitis B OR Hepatitis A/B combo (Twinrix)</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #3 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>#1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #3 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
</tr>
<tr>
<td><strong>Submitted HBsAB titer documentation</strong></td>
<td><strong>Submitted HBsAB titer documentation</strong></td>
</tr>
</tbody>
</table>

### History of Chicken Pox Illness AND Positive IgG titer OR 2 doses of varicella-containing vaccine given on or after 12 months of age and at least 28 days apart AND Varicella IgG titer **REQUIRED:** Students without a history of disease, with one prior dose of vaccine, or with a negative antibody titer should receive a total of two doses of vaccine followed by a Varicella IgG titer 2 months after receiving the 2nd dose. If your varicella titer result is negative, make sure the correct titer was performed, IgG, not IgM. ***NOTE: All titers must include a lab report.***

<table>
<thead>
<tr>
<th>Illness __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
<th>OR</th>
<th>Varicella Vaccine #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
<th>AND</th>
<th>Submitted varicella titer</th>
</tr>
</thead>
</table>

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### Recommended Vaccines (not required):

<table>
<thead>
<tr>
<th>Seasonal Influenza (different requirements per program) __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
<th>Meningococcal __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
<th>Pneumococcal __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gardasil #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #3 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Cervarix #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #3 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Bexsero #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #3 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
</tr>
<tr>
<td>or</td>
<td>Trumenba #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #3 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td><strong>Travel Vaccines (not required):</strong> Hepatitis A #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, Yellow Fever __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, Polio Booster __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
</tr>
<tr>
<td>Rabies #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #3 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #4 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td></td>
<td>IXIARO #1 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, #2 __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, Typhoid (IM) __________/<strong><strong><strong><strong>/</strong></strong></strong></strong>, Typhoid (Oral) __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
</tr>
</tbody>
</table>

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**Form must be completed by a MD, DO, PA, NP, RN or LPN. Official stamp from a doctor’s office, clinic or health department AND an authorized signature must appear on this form.**

Provider Name (print): ___________________________ **Title:** __________ **Phone #:** ___________________________

Provider Signature: ___________________________ **Date:** __________/________/________

**Address/Official Stamp Here:** ___________________________

**Mail to:** Duke Student Health Services, Attention: Immunization Department, DUMC 2899, Durham, NC 27710 OR Fax to 1.919.681.7386 OR Email (Preferred Method) to immunizations@duke.edu

**IMPORTANT! KEEP A COPY OF THIS PAGE AND ALL LAB/CHEST X-RAY REPORTS FOR YOUR RECORDS.**
Tuberculosis screening questionnaire for health science students.

Section A: Tuberculosis (TB) Exposure Risk

1. Do any of the following conditions or do any of the following situations apply to you?
   a) Have you ever lived with or been in close contact to a person known or suspected of being sick with Active TB? [YES ☐ NO ☐]
   b) Have you ever lived, worked or volunteered in any homeless shelter, prison/jail or healthcare facility? [YES ☐ NO ☐]
   c) Have you ever used recreational IV drugs? [YES ☐ NO ☐]

2. Have you ever received the Bacille Calmette-Guerin (BCG) vaccine? [YES ☐ NO ☐]

3. Were you born in, or have you lived, worked, or traveled to one or more of the areas listed in the box below for >1 month? [YES ☐ NO ☐]

Section B: Have you ever had a positive TB test? [YES ☐ NO ☐]

If you answered yes do not need a repeat TB test. You must have a Chest X-ray that must be done within 12 months preceding the start of school and completed in the U.S.

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. after June 1 of your entering year. 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. This must be done in the US by your provider or at Duke University Student Health.

Tuberculin Skin Test Date placed: __/__/____ Date read: __/__/____ Results: ___ # of mm induration

OR

QFT-G OR T-Spot: (MUST SUBMIT LAB REPORT AND MUST BE DONE IN THE UNITED STATES)

Chest x-ray (CXR): (MUST ATTACH RADIOLOGY REPORT AND MUST BE DONE IN THE UNITED STATES WITHIN THE PAST 12 MONTHS)

Provider Name (print): ___________________________ Title: ____________________ Phone: ___________________________

Provider Signature: _______________________________ Date: __/__/____

Address/Official Stamp Here: ________________________________

Mail to: Duke Student Health Services, Attention: Immunization Department, DUMC 2899, Durham, NC 27710 OR Fax to 1.919.681.7386

OR Email (Preferred Method): immunizations@duke.edu

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