Point UNIVERSITY

Required Certificate of Immunization

Student Information

Complete the information below. Return the completed form to Point, and retain a copy for your records.

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address (Current): _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____ Phone Number: _____

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Gender: ☐ Female ☐ Male

Signature: _____ Date: _____

Required Immunization Information

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR[1]	/ /	/ /			
Measles[1]	/ /	/ /			/ /
Mumps[1]	/ /	/ /			/ /
Rubella[1]	/ /	/ /			/ /
Varicella[3]	/ /	/ /		(History of Varicella) / /	/ /
Tetanus-Diphtheria (DTP, DTaP, Tdap or Td within 10 years)	(Most recent date) / /				
Hepatitis B[2]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /

[1]Not required if born before 1957. [2]Only required of students who are 18 years of age or younger at time of expected enrollment.

[3]Required for all U.S.-born students born in 1980 or later; all foreign-born students regardless of year born.

Permanent or Temporary Immunization Exemption

☐ This student is exempt from the above immunizations on the ground of permanent medical contraindication.
☐ This student is temporarily exempt from the above immunization until _____/_____/_____.

Certification Of Health Care Provider *(This information is required)*

Name of Physician: _____ Signature: _____

Address: _____ _____

Date: _____ Phone: _____

Exemptions

☐ I declare that I will be enrolling in ONLY courses offered by the Adult and Professional Studies Program. I understand that if I register for a traditional course, this exemption becomes void and I will be excluded from class until I provide proof of immunization.

Student Signature: _____ Date: _____

Point UNIVERSITY

Recommended Certificate of Immunization

Student Information

Complete the information below. Return the completed form to Point, and retain a copy for your records.

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address (Current): _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____ Phone Number: _____

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Gender: ☐ Female ☐ Male

Signature: _____ Date: _____

Recommended Immunization Information

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
Human Papillomavirus[4]	/ /	/ /	/ /		
Hepatitis A[5]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /
Meningococcal[5]	/ /	/ /			
Influenza[5]	/ /	/ /	/ /		

[4]Strongly recommended for all unvaccinated women through age 26 years. [5]Strongly recommended, but not required.

Certification Of Health Care Provider *(This information is required)*

Name of Physician: _____ Signature: _____

Address: _____ _____

Date: _____ Phone: _____

Student Signature: _____ Date: _____

Please return all immunization and medical forms to:
Point University, Admission Office
507 West 10th Street, West Point, GA 31833
or fax to: 706-645-9473

Point UNIVERSITY

Required Tuberculosis Screening Form

Student Information

Complete the information below. Return the completed form to Point, and retain a copy for your records.

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address (Current): _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____ Phone Number: _____

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Gender: ☐ Female ☐ Male

Signature: _____ Date: _____

Tuberculosis Screening Information

Are you a member of a high-risk group or are you entering the health professions?[1]

☐ Yes ☐ No

If **NO**, sign and date the bottom of the form and return to ACC. No further evaluation is needed at this time.
If **YES**, the remainder of the form must be completed by medical personnel.

1. **Does the student have signs or symptoms of active TB disease?** ☐ Yes ☐ No

   If **NO**, sign and date the form below. If **YES**, proceed with additional evaluation to exclude active TB disease, including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. **Tuberculin Skin Test:**

   Date given: _____ / _____ / _____ Date read: _____ / _____ / _____

   Result: _____ *(Record actual mm of induration, transverse diameter; if no induration, write "0")*

   Interpretation *(based on mm of induration as well as risk factors)*: ☐ positive ☐ negative

3. **Chest x-ray *(required if tuberculin skin test is positive)*:**

   Result: ☐ normal ☐ abnormal Date of chest x-ray: _____ / _____ / _____

Certification Of Health Care Provider *(Required if student is a member of a high-risk group or is entering the health professions)*

Name of Physician: _____ Signature: _____

Address: _____ _____

Date: _____ Phone: _____

Student Signature *(Required of all students)*

Signature: _____ Date: _____

[1]Categories of high-risk students include those students who have arrived within the past 5 years from countries where TB is endemic, or who have traveled within the past year to a high-risk area and have not subsequently been tested. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection; who inject drugs; who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone ≥ 15 mg/d for ≥ one month) or other immunosuppressive disorders.

Point UNIVERSITY

Meningococcal Disease Information Sheet

Meningococcal Disease

The following information is provided to you as required by law. Please sign the accompanying acknowledgement form and return as directed.

The Georgia General Assembly passed legislation requiring public and nonpublic postsecondary educational institutions to give students residing in campus housing information about meningococcal disease and vaccine. Students are required to sign a document provided by the postsecondary institution stating that they have received a vaccination against meningococcal disease or reviewed the information and declined to be vaccinated. The governor signed the legislation on May 28, 2003; effective January 1, 2004 (Official Code of Georgia Annotated § 31-12-3.2).

Meningococcal Disease Facts

- Meningococcal disease is a serious infection caused by bacteria, most commonly causing meningitis (an infection of the membranes that surround the spinal cord and brain) or sepsis (an infection of blood that affects many organ systems).
- College freshmen, particularly those living in residence halls, have a modestly increased risk of getting the disease compared with other persons of the same age. Up to 100 cases occur among the 15 million college students in the United States each year, with 5-15 deaths. However, the overall risk of disease, even among college students, is low.
- Crowded living conditions and smoking (active or passive) are additional risk factors that are potentially modifiable.
- Bacteria are spread from person to person through secretions from the mouth and nose, transmitted through close contact. Casual contact or breathing in the same air space is not considered sufficient for transmission.
- Common symptoms include: stiff neck, headache, fever, sensitivity to light, sleepiness, confusion, and seizures. Invasive meningococcal disease, or blood infection with the organism, causes fever and rash.
- The disease can be treated with antibiotics, but treatment must be started early. Even with treatment, some patients may die. Survivors may be left with a severe disability, such as the loss of a limb.
- A meningococcal polysaccharide vaccine is available for those who wish to pay for it.
- Vaccine protects against 4 of the 5 most common types of meningococcal bacteria, and protection typically lasts 3-5 years.
- Vaccination may decrease the risk of meningococcal disease; however, it does not eliminate the risk because the vaccine does not protect against all types of meningococcal bacteria. Approximately 50-70% of disease among college students is likely to be vaccine-preventable.
- Vaccine may be available at travel clinics, health departments, student health services, or through private providers. Prices may vary.
- Information about meningococcal disease:
    - The availability of a safe and effective vaccine: http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf
    - A listing of additional sources of information: http://www.cdc.gov/vaccines/recs/schedules/teen-schedule.htm
    - Map of Georgia's public health districts: http://www.usg.edu/student_affairs/faq/immun/resources_map.pdf

Point UNIVERSITY

Meningococcal Disease Acknowledgement Form

Meningococcal Disease

Information about meningococcal disease has been provided to you as required by law. Please sign this form and return as directed, even if you are not planning to live in campus housing.

The Georgia General Assembly passed legislation requiring public and nonpublic postsecondary educational institutions to give students residing in campus housing information about meningococcal disease and vaccine. Students are required to sign a document provided by the postsecondary institution stating that they have received a vaccination against meningococcal disease or reviewed the information and declined to be vaccinated. The governor signed the legislation on May 28, 2003; effective January 1, 2004 (Official Code of Georgia Annotated § 31-12-3.2).

Student Information

Complete the information below. Return the completed form to Point, and retain a copy for your records.

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address (Current): _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____ Phone Number: _____

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Gender: ☐ Female ☐ Male

In keeping with the law, I, _____, acknowledge I have
(print name)

☐ received a vaccination against meningococcal disease,

or

☐ reviewed the information provided to me by the institution and declined to be vaccinated.

Student Signature: _____ Date: _____

Parent or guardian signature required for all students under 18:

Parent or Guardian's Signature: _____

Parent or Guardian's Printed Name: _____

Relationship to Student: _____ Date: _____

Please return all immunization and medical forms to:
Point University, Admission Office
507 West 10th Street, West Point, GA 31833
or fax to: 706-645-9473

Point UNIVERSITY

Required Medical Information Form

Home or Family Physician

Name of Physician: _____

Medical Facility Address: _____ Phone: _____

City: _____ State: _____ ZIP Code: _____

Emergency and Insurance Information

Person(s) to contact in an emergency:

Name: _____

Relationship: _____ Phone Number: _____

Name: _____

Relationship: _____ Phone Number: _____

Do you have medical insurance? ☐ Yes ☐ No

Insurance Company: _____ Phone Number: _____

Policyholder's Name: _____ Social Security Number: _____ - _____ - _____

Relationship to Student: _____

Policy Number: _____ Group Number: _____

Consent for Treatment and Statement of Accuracy

I, _____ (student name), authorize employees or agents of Point University to enlist medical, nursing and emergency care on my behalf, including but not limited to diagnostic procedures, medical treatment and any other procedures that may in their judgment be deemed necessary or beneficial.

I understand that the practice of medicine and nursing is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations or treatment of my condition.

I certify that I have read the forgoing and give my consent. I also certify that the information provided above is true to my knowledge.

Student's Signature: _____ Date: _____

Student's Printed Name: _____

Parental consent required for all dependent students:

Parent or Guardian's Signature: _____

Parent or Guardian's Printed Name: _____

Relationship to Student: _____ Date: _____

Point University requires that all students possess primary health insurance for the duration that they are enrolled. In the event you do not have access to coverage, please contact Anthem (BCBS), which provides plans including medical and athletic injury coverage, at http://www.healthplansforcollegestudents.com/, or by calling 1-888-830-3520.

Please return all immunization and medical forms to:

Point University, Admission Office

507 West 10th Street, West Point, GA 31833

or fax to: 706-645-9473