CHOATE Rosemary Hall

IMMUNIZATION RECORD (LIST DATES OF VACCINATION AS MM/DD/YYYY)

Name of student: _____ **Date of birth** *(MM/DD/YYYY)*_____

The following immunizations are **REQUIRED FOR STUDENTS TO ATTEND CLASSES** by the State of Connecticut and/or Choate Rosemary Hall. This form **MUST BE completed by a physician, PA or APRN**. Please complete this form or attach a copy of the patient immunization record. **Record must be legible and in English. If the record is not in English, please have provider copy dates onto this form.** All documented doses should meet the age and interval criteria in the Child and Adolescent Immunization Schedule recommended by the Advisory Committee for Immunization Practices (ACIP) and published by the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/vaccines/hcp/imzschedules/child-adolescent-age.html

REQUIRED VACCINES	1st Dose MM/DD/YYYY	2nd Dose MM/DD/YYYY	3rd Dose MM/DD/YYYY	4th Dose MM/DD/YYYY
DTaP- (Diphtheria, Tetanus and Pertussis) - **At least 3 doses** required, one of which should be Tdap.				
Tdap - (Tetanus, Diphtheria, and Pertussis). Booster within last 10 years.				
Polio - **At least 3 doses** required. The **last dose must be on or after the 4th birthday**. Check the appropriate box. ☐Oral (LAIV/OPV) ☐Injectable (IPV)				
MMR * - (Measles, Mumps, Rubella) - **2 doses required.** First dose **MUST be on or AFTER 1st birthday**. Second dose MUST be at least 28 days after the 1st dose.				
Hepatitis B series * - **3 doses required**. At least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; 16 weeks between doses 1 and 3. Dose 3 should not be given before 24 weeks of age.				
Hepatitis A series * - **2 doses required** for those born on or after Jan. 1st, 2007. First dose **MUST be on or AFTER 1st birthday**. Second dose must be 6 months after the 1st dose.				
Varicella * (Chickenpox) - **2 doses required**. First dose **MUST be on or AFTER 1st birthday**. Minimum interval between doses: 3 months if person was younger than 13 years or 28 days if person was 13 or older.				
Meningitis ACWY - 1st dose required at age 11-12 years and 2nd dose at 16 years. If the first dose was given between 13-15 years, the 2nd dose should be given between 16-18, with at least 8 weeks between doses. If the 1st dose was given after age 16, only 1 dose is required. *Protection from this vaccine only lasts for ~5 years, so those who were vaccinated more than 5 years ago will require a booster.*				

* Laboratory confirmation of immunity acceptable, if performed. Please attach results.

ADDITIONAL VACCINES

Recommended (not required) Vaccines	Dose 1 (Mo/Day/Yr)	Day 2 (Mo/Day/Yr)	Day 3 (Mo/Day/Yr)
Covid - 19 Type: ☐Moderna ☐Pfizer ☐J&J			
HPV 2 doses required if 1st dose given before age 15. 3 doses required if 1st dose given at age 15 or older.			
Meningitis B			

LICENSED MEDICAL PROVIDER (MD, DO, PA, APRN) Verification

Provider name (print)_____
Provider Signature_____
Official role or title_____
Date signed _____

Provider/Office Stamp or seal

TB RISK ASSESSMENT FORM (to be completed by parent or guardian)

Please answer the following questions to determine your student's risk and review answers with your provider.

Please review list of countries and territories with high incidence of active TB disease:
Angola, Bangladesh, Brazil, Cambodia, Central African Republic, China, Congo, Democratic People's Republic of Korea, Democratic Republic of the Congo, Ethiopia, Gabon, Hong Kong, India, Indonesia, Kenya, Lesotho, Liberia, Mongolia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, South Korea, Thailand, Uganda, United Republic of Tanzania, Vietnam, Zambia, Zimbabwe. *World Health Organization's most up to date list can be found at https:///www.who.int/tb/country/data/profiles/en

1. Was your student born in one of the countries or territories with a high incidence of TB (see list above)?	☐ yes ☐ no If yes, where? _____
2. Has your student had frequent or prolonged trips (>4 weeks) to a country or territory with high incidence of TB (see list above)?	☐ yes ☐ no If yes, where? _____
3. Has your student ever been in close contact with a person known or suspected to have active TB?	☐ yes ☐ no
4. Has your student ever been a resident of or volunteered in a high-risk congregate setting (e.g. long-term care facility, homeless shelter, or correctional facility)?	☐ yes ☐ no
5. Does your student have a prior history of testing positive on a PPD (tuberculin skin test/TST) or IGRA (Quantiferon Gold/T-spot) test?	☐ yes ☐ no

***If you answered "yes" to any of the above questions, then your healthcare provider must complete the "Tuberculosis Clinical Assessment by Healthcare Provider." If you answered "no" to all of the above questions, no further action required.

TUBERCULOSIS CLINICAL ASSESSMENT by Healthcare Provider

*Signs of Active TB must be ruled-out by a healthcare provider***

History of a positive TB skin test (TST/PPD) or IGRA blood test? ☐ yes ☐ no

- If a student reports HISTORY of positive TST/PPD or IGRA, and has no symptoms of active disease, please complete the "Chest xray" or "treatment" section below.
- For a student with a history of a positive screening test and subsequent normal chest xray, no further testing is required if tests were done within the last 5 years and the student has no new risk factors.
- **For all students who answered yes to questions on the TB screening form, please proceed with a screening test with TST/PPD or IGRA. IGRA preferred.**
- For students who test positive on screening test, exhibit no signs of active TB and have a negative chest xray, **treatment for LATENT TB is recommended per current guidelines.**

Screening Tests

TB Skin Test (TST/PPD)	Date placed _____ Date read_____ **Size of induration:** _____mm **Result:** ☐ negative ☐ postive
IGRA (Quantiferon Gold) ☐QFT-GIT ☐T-SPOT	**Date:** _____ **Result: ☐negative ☐postitive ☐indeterminate/borderline** ***Please attach lab report**

Chest X-ray: Required after positive screening test

Date performed: _____	**Result: ☐normal ☐abnormal** ***Please attach radiology report**

Treatment (current or history)

Treatment for:	Medication(s)	Dosages	Frequency	Start date	Completion Date
☐ Latent TB ☐ Active TB					

****If currently on treatment, please complete medication authorization form and Medication supplemental form**

LICENSED MEDICAL PROVIDER (MD, DO, PA, APRN) Verification

Provider name (print) _____ Official role or title_____

Provider Signature_____ Date signed _____

Name of Clinic/Office _____

Provider/Office Stamp or seal: