East Georgia STATE COLLEGE

ALL FORMS MUST BE COMPLETED IN ENGLISH

Fax this completed form to 478-289-2353 at least 4 weeks prior to orientation (PAWS) date to EGSC Student Affairs. For any questions, email: ASK_EGSC@EGA.EDU

Name: _____ Student ID#: _____

Address: _____ Date of Birth: _____ Age: _____

_____ Phone: _____

CERTIFICATE OF IMMUNIZATION (REQUIRED)

REQUIRED IMMUNIZATIONS	REQUIREMENT		REQUIRED
MMR (Measles, Mumps, Rubella) combined shot	•2 Doses	#1 _____/_____/_____ #2 _____/_____/_____	• Students born in 1957 or later
OR		**OR**	
•Measles (Rubeola)	•2 Doses	#1 _____/_____/_____ #2 _____/_____/_____	• Students born in 1957 or later
	•or Titer	_____/_____/_____	
and		**and**	
•Mumps	•2 Doses	#1 _____/_____/_____ #2 _____/_____/_____	• Students born in 1957 or later
	•or Titer	_____/_____/_____	
and		**and**	
•Rubella (German Measles)	•1 Dose	#1 _____/_____/_____	**• Students born in 1957 or later.**
	•or Titer	_____/_____/_____	**• Attach titer results.**
Varicella (Chicken Pox)	•2 Doses **•or** History of chicken pox or shingles	#1 _____/_____/_____ #2 _____/_____/_____ _____/_____/_____	• All U.S. born students born in 1980 or later and all foreign born students regardless of year born
	•or Titer	_____/_____/_____	**•Attach titer results.**
Tetanus-Diphtheria-Pertussis (Whooping Cough) or Td booster	•Tdap •Td Booster	_____/_____/_____ _____/_____/_____	• All students must have one dose of Tdap and a Td booster if Tdap ≥10 years prior
Hepatitis B	•3 Dose series	#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____	•All students 18 years of age and under at matriculation **• Attach titer results.**
Tuberculosis screening	•Must complete TB screening questionnaire		•All students. All students, with risk noted, must complete the TB Risk Assessment

STRONGLY RECOMMENDED	**IMMUNIZATIONS**			
Hepatitis A	2 Doses	#1 _____/_____/_____	#2 _____/_____/_____	
Human Papillomavirus (HPV)	3 Doses	#1 _____/_____/_____	#2 _____/_____/_____	#3 _____/_____/_____
Meningitis (A,C,Y,W135)		#1 _____/_____/_____	#2 _____/_____/_____	
Meningitis B	2 or 3 Doses	#1 _____/_____/_____	#2 _____/_____/_____	#3 _____/_____/_____
Other vaccines:	_____	_____/_____/_____	_____	_____/_____/_____

REQUEST FOR EXEMPTION

Religious Exemption - In the event of an outbreak, exempted persons may be subject to exclusion from school and to quarantine, until proof of vaccination(s) is provided.
If religious exemption is required, please sign here - Student Signature: _____

Please print and sign before submitting if applicable.

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

Name: _____ Phone: _____

Address: _____

Signature: _____ Date: _____

Please print and sign before submitting.

IMMUNIZATION REQUIREMENTS

Applicants **MUST SUBMIT ONE OF THE FOLLOWING** in order to document proof of required immunizations listed below. No other documentation will be accepted.

- East Georgia State College Certificate of Immunization
- Georgia Registry of Immunization Transactions and Services (GRITS) printout
- World Health Organization (WHO) Certificate of Immunization
- Georgia County Health Department Immunization History Printout
- Georgia Department of Human Resources Certificate of Immunization (Form 3231)
- University System of Georgia Institution Certificate of Immunization

PROOF OF IMMUNIZATION OR NATURALLY ACQUIRED IMMUNITY REQUIRED

Vaccine	Requirement	Required for:
Measles (Rubeola)	Two (2) doses of live measles vaccine (combined measles-mumps-rubella or "MMR" meets this requirement), with the first dose at 12 months of age or later and the second dose at least 28 days after the first dose **OR** laboratory or serologic evidence of immunity	Students born in 1957 or later
Mumps	One (1) dose at 12 months of age or later (MMR meets this requirement) **OR** laboratory or serologic evidence of immunity	Students born in 1957 or later
Rubella (German Measles)	One (1) dose at 12 months of age or later (MMR meets this requirement) **OR** laboratory or serologic evidence of immunity.	Students born in 1957 or later
Varicella (Chicken Pox)	(2) doses spaced at least 3 months apart if both doses are given before the student's 13th birthday or 2 doses at least 4 weeks apart, if first dose is given after the student's 13th birthday or reliable history of varicella disease (chicken pox) or laboratory/serologic evidence of immunity or history of herpes zoster (shingles)	All U.S. born students born in 1980 or later. All foreign born students regardless of year born
Tdap (must be administered on or after 6/10/2005)	One Tdap dose within 10 years prior to matriculation.	All students
Hepatitis B	Three (3) dose hepatitis B series (0 ,1-2 and 4-6 months) OR Three (3) dose combined hepatitis A and hepatitis B series (0, 1-2 and 6-12 months) **OR** Two (2) dose hepatitis B series of Recombivax (0 and 4-6 months, given at 11-15 years of age) **OR** laboratory or serologic evidence of immunity.	Required for all students who will be 18 years of age or less at the time of expected enrollment. *Recommendation:It is **strongly recommended** that all students, regardless of their age at matriculation, discuss hepatitis B immunization with their health care provider.*
TB Screening	Completion of GSU TB screening questionnaire is required.	All students
Meningococcal Vaccine (Strongly Recommended for all students under the age of 22)	Menactra or Menveo (MCV4) **OR** Menactra or Menveo Booster (If first dose more than 5 yrs prior to admittance)	• All newly admitted EGSC students living in Campus Housing. • **NOTE**: A student may sign a statement of understanding in lieu of providing proof of immunization.

ADDITIONAL IMMUNIZATION RECOMMENDATIONS - NOT REQUIRED

Vaccine	Recommendation
Influenza	Annual vaccination at the start of influenza season (August-March)
Hepatitis A	Two (2) dose hepatitis A series (0 and 6-12 months), OR Three (3) dose combined hepatitis A and hepatitis B series (0, 1-2 and 6-12 months)
Other Vaccines	Other vaccines may be recommended for students with underlying medical conditions and students planning international travel. Students meeting these criteria should consult with their physicians or health clinic regarding additional vaccine recommendations.
Human Papillomavirus	3 dose HPV series. Dose #2 is given 4-8 weeks after dose #1 and dose #3 is given 6 months after dose #1 (at least 10 weeks after dose #2)

EMAIL ANY QUESTIONS TO ASK_EGSC@EGA.EDU

East Georgia STATE COLLEGE™

ALL FORMS MUST BE COMPLETED IN ENGLISH

Fax this completed form to 478-289-2353 at least 4 weeks prior to orientation (PAWS) date to EGSC Student Affairs. For any questions, email: ask_egsc@ega.edu

Name:_____ Student ID:_____

Address:_____ Date of Birth:_____ Age:_____

_____ Phone:_____

Part I: Tuberculosis (TB) Screening Questionnaire (Required for *ALL* incoming students)

Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No
2. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) ❑ Yes ❑ No

Afghanistan	Congo	Iran (Islamic Republic of)	Namibia	Singapore
Algeria	Côte d'Ivoire	Iraq	Nauru	Solomon Islands
Angola	Democratic People's Republic of Korea	Kazakhstan	Nepal	Somalia South Africa
Anguilla		Kenya	Nicaragua	South Sudan
Argentina	Democratic Republic of the Congo	Kiribati	Niger	Sri Lanka
Armenia		Kuwait	Nigeria	Sudan
Azerbaijan	Djibouti	Kyrgyzstan	Northern Mariana Islands	Suriname
Bangladesh	Dominican Republic	Lao People's Democratic Republic		Swaziland
Belarus	Ecuador		Pakistan	Tajikistan
Belize	El Salvador	Latvia	Palau	Thailand
Benin	Equatorial Guinea	Lesotho	Panama	Timor-Leste
Bhutan	Eritrea	Liberia	Papua New Guinea	Togo
Bolivia (Plurinational State of)	Estonia	Libya	Paraguay	Trinidad and Tobago
Bosnia and Herzegovina	Ethiopia	Lithuania	Peru	Tunisia
Botswana	Fiji	Madagascar	Philippines	Turkmenistan
Brazil	French Polynesia	Malawi	Poland	Tuvalu
Brunei Darussalam	Gabon	Malaysia	Portugal	Uganda
Bulgaria	Gambia	Maldives	Qatar	Ukraine
Burkina Faso	Georgia	Mali	Republic of Korea	United Republic of Tanzania
Burundi	Ghana	Marshall Islands	Republic of Moldova	
Cabo Verde	Greenland	Mauritania	Romania	Uruguay
Cambodia	Guam	Mauritius	Russian Federation	Uzbekistan
Cameroon	Guatemala	Mexico	Rwanda	Vanuatu
Central African Republic	Guinea	Micronesia (Federated States of)	Saint Vincent and the Grenadines	Venezuela (Bolivarian Republic of)
Chad	Guinea-Bissau			
China	Guyana	Mongolia	Sao Tome and Principe	Viet Nam
China, Hong Kong SAR	Haiti	Montenegro	Senegal	Yemen
China, Macao SAR	Honduras	Morocco	Serbia	Zambia
Colombia	India	Mozambique	Seychelles	Zimbabwe
Comoros	Indonesia	Myanmar	Sierra Leone	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

3. Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No
4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No
5. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No
6. Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, sign below**.** GSU requires that you proceed to Part II, undergo TB testing and complete all subsequent sections. This clinical assessment and testing must be completed by a physician or healthcare facility no sooner than 6 months prior to arrival on campus and no later than 30 days following the first day of the initial semester at GSU.

If the answer is NO to all of the above questions, no further testing or action is required. Sign below and mail this signed form to: East Georgia State College, 131 College Cir, Swainsboro 30401 or fax to 478-289-2353.

Signature of Student or Parent/Guardian if student is UNDER 18 years old_____ **Date**_____

Signature of Health Services Reviewer or Healthcare Provider_____ **Date**_____

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

East Georgia STATE COLLEGE™ **ALL FORMS MUST BE COMPLETED IN ENGLISH**

Fax this completed form to 478-289-2353 at least 4 weeks prior to orientation (PAWS) date to EGSC Student Affairs.
For any questions, email: ask_egsc@ega.edu

Name:_____ Eagle ID:_____
Address:_____ Date of Birth:_____ Age:_____
_____ Phone:_____

***Testing should be performed no sooner than 6 months prior to arrival on campus.**

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I should receive either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes _____ No _____**

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes _____ No _____**

#1. TB Symptom Check
Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____

If No, proceed to either #2 (TST) or #3 (IGRA)

If yes, check below:

- Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated & include results where indicated below.

#2. Tuberculin Skin Test (TST)
If positive proceed to #4 (Chest X-ray) & include results where indicated below. If negative proceed to Part IV.
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

****Interpretation guidelines**

>5 mm is positive:
- recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:
- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:
- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

East Georgia STATE COLLEGE

ALL FORMS MUST BE COMPLETED IN ENGLISH

Fax this completed form to 478-289-2353 at least 4 weeks prior to orientation (PAWS) date to EGSC Student Affairs. For any questions, email: ask_egsc@ega.edu

Name:_____ Eagle ID:_____
Address:_____ Date of Birth:_____ Age:_____
_____ Phone:_____

#3. Interferon Gamma Release Assay (IGRA)

If positive proceed to #4 (Chest X-ray) & include results where indicated below. If negative proceed to Part IV.

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

#4. Chest x-ray (Required if TST or IGRA is positive)

If Chest X-ray is negative complete Part III and Part IV below.
If Chest X-ray is positive proceed sputum evaluation as indicated and complete Part III and Part IV below.

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Part III. Management of Positive TST or IGRA (to be completed by Health Care Professional)

All students with a positive TST or IGRA with no signs of active disease on chest x -ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

••Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

_____ Student agrees to receive treatment

_____ Student declines treatment at this time

****Students who have completed LTBI therapy, as well as those who elected not to take therapy, should be educated regarding signs and symptoms of TB disease and instructed to seek medical care immediately upon developing any of the signs or symptoms of TB.**

Part IV. Health Care Professional Signature

Name_____ Phone _____

Address _____ City, State, Zip Code _____

Signature _____ Date _____

East Georgia STATE COLLEGE

ALL FORMS MUST BE COMPLETED IN ENGLISH

Fax this completed form to 478-289-2353 at least 4 weeks prior to orientation (PAWS) date to EGSC Student Affairs.
For any questions, email: ASK_EGSC@EGA.EDU

Medical Entrance Form

Semester Beginning: _____ Date: _____

Student ID#:_____ DOB: _____Age at Time of Application_____

Name (Last, First, Middle):_____

Address: _____City:_____State:_____Country:_____

Zip Code: _____ Cell Phone :(____) _____Email:_____

***This information will remain confidential and will be utilized by Health Services personnel only.**

1. ALLERGIES (List all medication, food, insect or other known allergies below)

_____

_____

Do you receive allergy shots? YES NO If yes, please have your allergy records faxed to 478-289-2353.

_____

2. HOSPITALIZATION (List all prior hospitalizations, surgeries, and procedures)

_____

_____

3. MEDICATION (List all medications including doses that you are currently taking)

_____

_____

4. MEDICAL HISTORY

Are you now or have you been under the care of a physician for an ongoing illness/medical condition? YES NO

Do you have a chronic (long-lasting or persistent) medical condition that requires treatment or medication? YES NO

If yes please have your physician fax a summary of your treatment to 478-289-2353 that includes the following:

- Condition being treated
- Type of medicine
- Physician's name, address and phone number

Please check all that apply

___ Emphysema ___Cirrhosis ___ Fractures ___ Arthritis ___ Thyroid Trouble ___ Cardiovascular Disease
___ Tuberculosis ___Anemia ___ Migraines ___ Heart Disease ___ Prostate Trouble ___ Elevated Cholesterol
___ Pneumonia ___ Stroke ___ Hepatitis A ___ Osteoporosis ___ Ulcerative Colitis ___ Anxiety or Panic Disorder
___ Bronchitis ___ Asthma ___ Hepatitis B ___Crohn's Disease ___ Sickle Cell Disease ___ Irritable Bowe l Syndrome
___ Allergies ___ Ulcers ___ Hepatitis C ___Cystic Fibrosis ___ Gallbladder Disease
___ Diabetes ___ Cancer ___ Depression ___ Venous Thrombosis ___ High Blood Pressure
___ Post-traumatic Stress Disorder ___ Sexually Transmitted Infections ___ Frequent Urinary Tract Infections
___ Bleeding Disorder or Other Blood Disorders ___ Alcohol/Substance Abuse Problem ___ Other: _____

Do you have a living will, advanced directive, durable power of attorney for healthcare or physician order for life sustaining treatment? (If yes, submit with your medical records forms.) ___ YES ___ NO

East Georgia
STATE COLLEGE

1. AUTHORIZATION TO TREAT (If you are 18 years of age or <u>OVER</u>)

- The General Consent for treatment gives permission to personnel of East Georgia State College and Georgia Southern Health Services to perform a medical evaluation including obtaining a history, doing a physical exam, performing a diagnostic workup and providing treatment, including minimally invasive procedures such as venipuncture to draw blood, x-rays, and IV catheter insertion to administer medications or IV fluids.
- The patient has the right to refuse any treatment.
- A record of General Consent for Treatment will be stored in the patient's medical record.
- Duration of General Consent for Treatment has continuing force and effect until the patient revokes the consent.

I hereby authorize the physicians, physician assistants, and nurse practitioners of East Georgia State College, Georgia Southern Health Services and their agents or consultants, including those at area hospitals and/or Georgia Department of Public Health, to perform diagnostic and treatment procedures which in their judgment may be necessary while I am at East Georgia State College-Statesboro campus. I understand I am responsible for charges incurred.

Patient Signature: _____ **Date:** _____

6. AUTHORIZATION TO TREAT (If you are <u>UNDER</u> 18 years of age)

I hereby authorize the physicians, physician assistants, and nurse practitioners of East Georgia State College, Georgia Southern Health Services, and their agents or consultants, including those at area hospitals and/or Georgia Department of Public Health, to perform diagnostic and treatment procedures which in their judgment may be necessary while he/she attends East Georgia State College-Statesboro campus. I waive all claim to prior notification. I understand that every reasonable effort will be made to notify me in the event of a major illness or injury, or if the East Georgia State College or Georgia Southern Health Services physician feels it is necessary. I understand I am responsible for charges incurred.

Patient Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____**Date:** _____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____Country:_____ Zip Code: _____

Daytime Phone: (___) _____ Evening Phone: (__) _____Email:_____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____Country:_____ Zip Code: _____

Daytime Phone: (___) _____ Evening Phone: (__) _____Email:_____

<u>PLEASE NOTE:</u> RETURN THESE FORMS TO HEALTH SERVICES <u>AT LEAST FOUR WEEKS</u> <u>*PRIOR*</u> TO YOUR ORIENTATION (PAWS) DATE. ***Students should keep a copy of these forms for their personal records.***

Name: _____Student ID#:_____