Stamps Health Services

Welcome to Georgia Tech! We are excited that you will be joining the Georgia Tech community in the coming months. This packet contains the immunization forms that are required for all incoming students taking classes on the Atlanta campus. There is a three-step process you will need to complete.

1. Take these forms to your healthcare provider and have them complete the forms.
2. Enter your immunization dates at https://gatech.medicatconnect.com.
3. Upload your completed forms at https://gatech.medicatconnect.com.

Important Note:

1. If you turn in immunization records that are not transferred onto our forms, you will likely miss completing one or more of our requirements. Most state immunization forms and previous college records may not include the items below.

    a. A Tuberculosis assessment.
    b. An adult dose Tdap vaccine.
    c. The appropriate Meningococcal (ACWY) vaccine.
    d. History or disease for Varicella is not accepted at Georgia Tech.

We want the process of completing our immunization requirements to be easy for you. The best way to accomplish this is to utilize the attached forms to ensure all the requirements are satisfied.

1. Please allow 5 – 7 business days for processing once you submit your forms. We will contact you at your Georgia Tech email if any additional action is needed on your part. You can check your immunization status and messages in our patient portal: https://gatech.medicatconnect.com.

If you need any assistance, please contact our immunization coordinator at immunizations@health.gatech.edu.

Stamps Health Services

CERTIFICATE OF IMMUNIZATIONS (All Students)

Please upload completed forms and enter immunization dates at https://gatech.medicatconnect.com

Please read ALL instructions below. Your records MUST meet these criteria to satisfy the requirements.

Name (Last, First, Middle) _____ **Country of Birth:** _____

GT ID#: _____ Birth Date: _____Cell Phone #: _____

Semester Beginning: _____ Email: _____

Required Immunizations					
Vaccine	Injection 1 Date MM/DD/YYYY	Injection 2 Date MM/DD/YYYY	Injection 3 Date MM/DD/YYYY	**OR**	Lab Report Confirming Immunity
MMR (Measles, Mumps, Rubella) **or** Measles + Mumps + Rubella 2 doses on or after first birthday at least 28 days apart.	/ /	/ /			
	/ /	/ /		**OR**	Attach Lab Report in English
	/ /	/ /		**OR**	Attach Lab Report in English
	/ /			**OR**	Attach Lab Report in English
Varicella History of Disease Not Accepted 2 doses on or after first birthday at least 28 days apart.	/ /	/ /		**OR**	Attach Lab Report in English
Tetanus-Diphtheria-Pertussis Tdap on or after 10th birthday and Tetanus booster if > 10 years since Tdap dose	/ / Tdap on or after 10th birthday	/ / Tetanus booster if > 10 years since Tdap dose			
Hepatitis B ☐2 Dose Series (Heplisav-B) ☐3 Dose Hep B Series (0, 1, 6 month) ☐3 Dose Twinrix Series	/ /	/ /	/ /	**OR**	Attach Lab Report in English
Meningococcal ACWY Given on or after 16th birthday Required for those under age 22	/ /	/ /			
Tuberculosis Screening (must be completed no more than 6 months prior to the start of class)	**U.S./Canadian Born Students** - **Complete Page 3** (TB Assessment, required, performed in the U.S. or Canada) and Page 4 (If TB Assessment indicates at risk) **International Born Students** - Complete an IGRA (Interferon Gamma Release Assay) blood test. If IGRA test is positive, Chest x-ray performed in the US is required. If receiving live vaccines at the same time as IGRA testing, IGRA test must be performed on the same day as the live vaccines or 28 days later. **Attach IGRA lab report in English.**				

Recommended Vaccines				
Hepatitis A		/ /	/ /	
HPV		/ /	/ /	/ /
Covid-19	**Brand:**	/ /	/ /	/ /
	Brand:	/ /	/ /	/ /
Meningococcal B	**Bexsero**	/ /	/ /	
	Trumenba	/ /	/ /	/ /

SIGNATURE OF HEALTH CARE PROVIDER AND DATE REQUIRED

Name: _____

Signature: _____

Phone: _____ **Date:**_____

PHYSICAN OFFICE STAMP

Stamps Health Services

TUBERCULOSIS (TB) ASSESSMENT FORM (REQUIRED)

US/CANADIAN BORN STUDENTS ONLY

Please upload completed form and enter assessment date at https://gatech.medicatconnect.com

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

All international born students must receive an IGRA (Interferon Gamma Release Assay) test.

Name (Last, First, Middle) _____ **Country of Birth:** _____

GT ID#: _____ Birth Date: _____ Cell Phone #: _____

Semester Beginning: _____

TB assessment must be completed no more than six months prior to start of classes within the U.S. or Canada.

1. Have your ever received a BCG (Bacillus Calmette–Guérin) vaccine?	☐ **Yes**	☐ **No**
If yes to question one, IGRA blood test is required. STOP HERE, complete certification of healthcare provider below then proceed to page 4 and complete section B.		
2. Have you ever had a positive test for tuberculosis (blood or skin test)?	☐ **Yes**	☐ **No**
If yes to question two, STOP HERE, complete certification of healthcare provider below, then proceed to page 4 and complete sections C and D.		
3. Have you had contact with a person known or suspected to have active TB disease?	☐ **Yes**	☐ **No**
4. Do you have any signs or symptoms or active TB disease: unexplained fever, unexplained weight loss, loss of appetite, night sweats, persistent cough for more than three weeks, coughing up blood?	☐ **Yes**	☐ **No**
5. Have you lived, worked, or volunteered in the following types of facilities: hospital, homeless shelter, long term care facility, rehabilitation facility, prisons, nursing home, residential facility for patients with AIDS?	☐ **Yes**	☐ **No**
6. Have you had frequent or prolonged visits to one or more of the countries or territories listed below with a moderate or high prevalence of TB disease regardless of length of time in the US?	☐ **Yes**	☐ **No**
If yes to one or more of questions three through six, complete certification of healthcare provider below then proceed to page 4 and complete section A or B. If no to all the above questions, complete certification of healthcare provider below.		

CERTIFICATION OF HEALTHCARE PROVIDER AND DATE REQUIRED

Is this student at risk for TB Exposure? (Yes = One or more Yes responses above)

☐ **YES** (complete page 4 per instructions above) ☐ **NO** (If not at risk, page 4 not required)

Provider Name: _____ Date: _____

Signature: _____Phone # _____

Countries with moderate or high risk of TB:

Afghanistan	Central African Republic	Guatemala	Malawi	Palau	Tajikistan
Algeria	Chad	Guinea	Malaysia	Panama	Tanzania UR
Angola	China	Guinea-Bissau	Maldives	Papua New Guinea	Thailand
Argentina	Colombia	Guyana	Mali	Paraguay	Timor-Leste
Armenia	Comoros	Haiti	Marshall Islands	Peru	Togo
Azerbaijan	Congo	Honduras	Mauritania	Philippines	Tunisia
Bangladesh	Congo (D.R. of)	India	Mexico	Qatar	Turkmenistan
Belarus	Cote d'Ivoire	Indonesia	Micronesia (FSM)	Romania	Tuvalu
Belize	Djibouti	Iraq	Moldova-Republic of	Russian Federation	Uganda
Benin	Dominican Republic	Kazakhstan	Mongolia	Rwanda	Ukraine
Bhutan	Ecuador	Kenya	Morocco	Sao Tome and Principe	Uruguay
Bolivia	El Salvador	Kiribati	Mozambique	Senegal	Uzbekistan
Bosnia and Herzegovina	Equatorial Guinea	Korea-DPR	Myanmar	Sierra Leone	Vanuatu
Botswana	Eritrea	Korea-Republic of	Namibia	Singapore	Venezuela (B.R. of)
Brazil	Eswatini	Kyrgyzstan	Nauru	Solomon Islands	Viet Nam
Brunei Darussalam	Ethiopia	Lao PDR	Nepal	Somalia	Yemen
Burkina Faso	Fiji	Lesotho	Nicaragua	South Africa	Zambia
Burundi	Gabon	Liberia	Niger	South Sudan	Zimbabwe
Cabo Verde	Gambia	Libya	Nigeria	Sri Lanka	
Cambodia	Georgia	Lithuania	Niue	Sudan	
Cameroon	Ghana	Madagascar	Pakistan	Suriname	

Stamps Health Services

TUBERCULOSIS TESTING FORM
(US/CANADIAN STUDENTS ONLY)

**Only if Page 3 indicates risk **

Please upload completed form at https://gatech.medicatconnect.com

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

Name (Last, First, Middle) _____ **Country of Birth:** _____

GT ID#: _____ Birth Date: _____ Cell Phone #: _____

Semester Beginning: _____

A.	**TST (Tuberculin Skin Test) – If test result is positive, please complete section D.** TST must be completed no more than six months prior to start of classes within the U.S. or Canada. Date placed:_____ Date read:_____ Result:_____mm ☐ **Positive** ☐ **Negative** A PPD/TST of ≥ 5 mm induration is considered positive for immunosuppressed students. A PPD/TST of ≥ 10 mm induration is considered positive for individuals with risk of exposure to TB. A PPD/TST of ≥ 15 mm induration is considered positive for students with no risk factors.
B.	**IGRA (Interferon Gamma Release Assay) Blood Test – If test result is positive, please complete section D.** **Please attach lab report in English.** IGRA = Quantiferon or T-Spot. If indeterminate or borderline results are received, repeat the test, or perform a chest x-ray in the United States or Canada.
C.	**History of a prior positive TST or IGRA** Date of positive TST:_____ OR Date of positive IGRA:_____ ☐ **Quantiferon** ☐ **T-Spot** **Please complete D below.**
D.	**Chest X-ray** **Please attach x-ray report.** Chest x-ray must be completed in the US/Canada only and must be completed no more than six months prior to the start of classes.
E.	**Treatment for latent TB** INH given? ☐ YES ☐ NO Rifampin ☐ YES ☐ NO Other Treatment:_____ Duration of Treatment: From _____ to_____ MM/DD/YY MM/DD/YY **If treatment received for latent TB, please complete D above.**

SIGNATURE OF HEALTHCARE PROVIDER AND DATE REQUIRED

Provider Name: _____

Signature: _____

Phone: _____ Date: _____

PHYSICAN OFFICE STAMP

Stamps Health Services

MEDICAL ENTRANCE FORM (REQUIRED)

UNDER 18 YEARS OF AGE ONLY

Please upload completed form at https://gatech.medicatconnect.com

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS

Semester Beginning: _____

GT ID#: _____ Cell Phone #: _____ Email:_____

Name (Last, First, Middle) _____

Address: _____ City:_____ State: _____ Country: _____

Zip Code: _____ Birth Date: _____

AUTHORIZATION TO TREAT

I hereby authorize the physicians, physician assistants and nurse practitioners of Stamps Health Services, including those at area hospitals, to perform diagnostic, preventative, and treatment procedures which in their judgment may be necessary while she/he attends Georgia Tech. 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 Stamps Health Services physician feels it is necessary.

Signature of parent/guardian: _____ **Date:** _____

Print Name: _____ **Relationship:** _____

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: _____