LENOIR-RHYNE UNIVERSITY

STUDENT HEALTH SERVICES

Immunization Requirements For:

- **High School Enrichment Program**
- **High School Scholars Academy**
- **University Christian High School**

Return to:

Student Health Center
LRU Box 7399
Hickory, N.C. 28603
or via Fax: 828-328-7348
or email: studenthealth.records@lr.edu

Questions:
Cornerstone Student Support and Wellness Center
(828) 328-7959

ALL HIGH SCHOOL PROGRAM STUDENTS MUST COMPLETE THIS PAGE – NO EXCEPTIONS!

All high school students attending LRU are required to have documentation of immunization status per NC State Law. Acceptable records for proof of immunization may be obtained from any of the following: High school transcript, personal shot records with official documentation, NC Immunization Registry copy, military record, health department, physician, or previously attended college. Records must have a physician's signature, clinic stamp, ***or*** agency letter head. Legible copies of the above are accepted. If not submitting a copy and completing the attached form, it must include the physician's signature **AND** clinic stamp. *Failure to submit completed records may prevent you from attending LRU classes and cause removal (if not received within 30 days of classes beginning).*

Name: _____ Date of Birth: _____

Home Address: _____

Phone: _____

Required Immunizations

- ☐ 3 DTP, TD, TDaP or Tdap doses. **NOTE**: one TD or Tdap dose must have been within the last **10** years. **If you are due for a dose a Tdap is required**.
- ☐ 3 oral polio doses.
- ☐ 2 measles, 2 mumps, and 1 rubella (MMR) doses or lab documented serological testing/titer proving immunity signed by your physician.
- ☐ 3 Hepatitis B doses.

3 DTP, TD, TDAP, or TDAP	#1	#2	#3 (this date must be in last 10 years)
3 Oral Polio	#1	#2	#3
2 Measles,	#1	#2	
2 Mumps	#1	#2	
1 Rubella	#1		
3 Hepatitis B (if born after July 1, 1994)	#1	#2	#3
Varicella (Chicken Pox) *Note: Titer or Vaccine dates only*	#1	#2	Or Serological testing / titer test results

_____ _____

Physician/NP/PA Signature & Clinic Stamp Date

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Last Name First Name Middle Name Date of Birth

TB: Tuberculosis (TB) Exposure Questionnaire- ALL students must complete. **NOTE: BCG VACCINATION DOES NOT EXEMPT TB SKIN TESTING**		
	YES	**NO**
Have you experienced any of the following symptoms: unexplained weight loss, loss of appetite, night sweats, fever, fatigue, a cough lasting longer than 3 weeks, chest pain, or hemoptysis (coughing up blood)?		
Have you ever been diagnosed with TB?		
Do you have HIV?		
Have you been in contact with a person with TB?		
Do you inject illicit drugs?		
Have resided in, been employed by, completed an internship, or volunteered in: prison, jail, long term care facility (nursing home), hospitals, other health care facilities, residential facilities for persons with AIDS or homeless shelters?		
Do you have ANY of the following conditions: silicosis, diabetes, chronic renal failure, hematological disorders, malignancies, 10% or more below your ideal weight, history of a gastrectomy or jejunoileal bypass, prolonged corticosteroid therapy, immunosuppressive therapy, pulmonary fibrotic lesions visible on a chest x-ray from prior untreated TB, or any other immunosuppressive disease?		
Visited (including a port stop on a cruise) or resided in a country of high TB prevalence with the past 5 years: Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands, or Eastern Europe (Albania, Belarus, Bosnia, Herzegovina, Bulgaria, Croatia, Czech Republic, Lithuania, Macedonia, Hungary, Latvia, Moldova, Poland, Romania, Russia, Serbia, Slovakia, Slovenia, Ukraine)		

If you answered "Yes" to any of the above questions or are an international student you need a PPD/Mantoux skin test to rule TB exposure. Your personal physician or local health department, can complete the test. If you have had a PPD/Mantoux in the last 12 months, those results are acceptable. If you have travelled to any of the above risk countries your PPD/Mantoux has to be performed after the travel.

Tuberculin Test Results (PPD/Mantoux)

Date Placed:	Date Read	Result: Positive Negative Induration: _____mm **Clinic stamp or signature of person reading**:
Date of Chest X-ray For Positive Result:	Chest X-ray Result:	Treatment (If abnormal chest x-ray) Date: (Provide copy of Physician's treatment orders/notes)