TAMUQ Use Only
UIN:_____

TEXAS A&M UNIVERSITY at QATAR

Immunization and Tuberculosis Screening Certificate

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2019-2020 Academic Year

IMPORTANT: Read the following information in its entirety.
Texas A&M University at Qatar requires all students at the time of registration to provide documentation of vaccination or immunity from Polio, Diphtheria, Tetanus, Hepatitis B, Measles, Mumps, Rubella, Varicella, and Meningitis. In addition, all students are required to have documentation of Tuberculosis skin test taken within the last year. Although not required, it is recommended that all students also be vaccinated for Hepatitis A, Typhoid, and HPV. ***This certification must be returned to TAMUQ by 11 July, 2019.*** Students and their families are encouraged to review the Ministry of Public Health guidelines on immunization and vaccine practice in the State of Qatar at www.hmc.org.qa/hmcnewsite/immunization.aspx.

In order to avoid delays, please see your healthcare provider as soon as possible to complete this certificate, especially if your immunization records are incomplete, and you need to get any required immunizations. ***You will not be able to enroll in classes until you provide this document.*** All immunization forms and copies must be submitted in English. It is your responsibility to ensure that all appropriate sections of this form are completed: Section 1 to be completed by student, Section 2 to be completed by parent/legal guardian (if necessary), and Section 3 to be completed by healthcare provider. **Please note this form has two sides.** If you have any questions, please send an email to immunizations@qatar.tamu.edu

Section 1. Student Information: To be completed by the student. *Please print legibly.*

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

Date of Birth: _____ (MM DD YYYY) **Country of Birth:** _____ **Nationality:** _____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married

Qatar ID: _____ **Email:** _____

Local Address: _____

Permanent Address: _____

Local Mobile Phone: _____ **Local Home Phone:** _____

Emergency Contact Name: _____ **Relationship to Student:** _____

Emergency Contact Number(s): _____

Primary Physician Name: _____ **Physician Number:** _____

Current Physical Conditions: _____

Current Mental Health/Learning Conditions: _____

Allergies: _____ **Current Medications:** _____

Exemption Request:

Religious exemption is allowed if the responsible person objects in good faith, *in writing,* that immunizations violate his or her religious beliefs. ***This exemption does not apply to tuberculosis screening.***

☐ **I request religious exemption.** _____ **Date:** _____
Signature of student

Medical exemption is allowed only if a physician or health authority deems an immunization medically inadvisable.

☐ **I request medical exemption.** _____ **Date:** _____
Signature of student

Explicit written documentation supporting either exemption request must be submitted with this certificate.

Section 2. Parental Consent: To be completed by parent or legal guardians of student under 18 years of age.

Consent from a parental or legal guardian is required in order to provide medical or surgical care to minors. The following statement should be signed by a parent or legal guardian for students under 18 years of age. This will prevent delays in treatment in the event of an illness or accident.

I hereby authorize the staff at Texas A&M University at Qatar to facilitate vaccinating, interviewing, assessment, testing and, if necessary, treatment of my child as deemed advisable.

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

Print Name: _____ **Phone:** _____

Section 3. Healthcare Record: To be completed by a healthcare provider.

A. Required immunizations.

Please put the date the vaccination was given. If medical records are not available, please mark the box indicating that lab results showing positive immunity have been attached for that particular illness.

1. **Last Polio:** ____/____/____ (MM DD YYYY) ***OR*** ☐ **Attached lab report showing positive immunity to Polio**

   ******Place the date when the series was completed. If series not completed, attach document indicating status of series completion.******

2. ***One of these boosters (Td or Tdap) **needs to be given within the past 10 years**.***

   Tetanus/Diphtheria (Td): ____/____/____ (MM DD YYYY) ***OR*** **Tetanus/Diphtheria/Pertussis (Tdap):** ____/____/____ (MM DD YYYY)

3. **Measles/Mumps/Rubella** ***OR*** **If MMR not used:**

   *****1st dose must be after 12 months of age. 2 doses required.*****

   MMR #1: ____/____/____ (MM DD YYYY)
   MMR #2: ____/____/____ (MM DD YYYY)

   Measles #1: ____/____/____ (MM DD YYYY) **Measles #2:** ____/____/____ (MM DD YYYY)
   Mumps #1: ____/____/____ (MM DD YYYY) **Mumps #2:** ____/____/____ (MM DD YYYY)
   Rubella #1: ____/____/____ (MM DD YYYY) **Rubella #2:** ____/____/____ (MM DD YYYY)

   OR

   ☐ **Attached lab report showing positive immunity to Measles**
   ☐ **Attached lab report showing positive immunity to Mumps**
   ☐ **Attached lab report showing positive immunity to Rubella**

4. **Hepatitis B #1:** ____/____/____ (MM DD YYYY) ***OR*** ☐ **Attached lab report showing positive immunity to Hepatitis B**
   Hepatitis B #2: ____/____/____ (MM DD YYYY)
   Hepatitis B #3: ____/____/____ (MM DD YYYY)

5. **Varicella #1:** ____/____/____ (MM DD YYYY) ***OR*** **Date of Chicken Pox:** ____/____/____ (MM DD YYYY)
   Varicella #2: ____/____/____ (MM DD YYYY)

   OR

   ☐ **Attached lab report showing positive immunity to Varicella (Chicken Pox)**

6. **Meningococcal:** ____/____/____ (MM DD YYYY) ***OR*** ☐ **Attached lab report showing positive immunity to Meningitis**
   *****(within the past 5 years)*****

B. Required Tuberculosis (TB) screening.

BCG is NOT a required vaccine. **BCG Vaccine:** ____/____/____ (MM DD YYYY) ☐ **No record of BCG vaccination**

A PPD-Mantoux test must be placed and interpreted by a healthcare provider *** (**within 12 months prior to registration**). ***
THIS MUST BE DONE REGARDLESS OF A BCG VACCINATION.

PPD placed: ____/____/____ (MM DD YYYY) **PPD read:** ____/____/____ (MM DD YYYY) **Result in mm in duration:** _____

Result: ☐ **PPD Result Positive** ***OR*** ☐ **PPD Result Negative**

In case of positively interpreted PPD, a follow-up with a healthcare provider is *required*. This follow-up must include a QuantiFERON-TB Gold test (QFT-G), a chest radiograph (x-ray), and a clinical evaluation checking for signs and symptoms suggestive of TB disease.

QFT-G: ____/____/____ (MM DD YYYY) **Result:** _____
X-Ray: ____/____/____ (MM DD YYYY) **Result:** _____
Medical Diagnosis: ____/____/____ (MM DD YYYY) **Result:** ☐ **Patient HAS TB** ***OR*** ☐ **Patient does NOT have TB**

C. Recommended immunizations.

The following vaccinations, while not required, are strongly recommended by The Counseling & Wellness Program.*** (HPV is for women only).***

******Place the date when the series was completed. If series not completed, attach document indicating status of series completion.******

1. Hepatitis A: ____/____/____ (MM DD YYYY) **2. Typhoid:** ____/____/____ (MM DD YYYY) **3. Human Papillomavirus (HPV) :** ____/____/____ (MM DD YYYY)

D. Signature and official stamp/seal of healthcare provider required.

Signature: _____ (Signature of healthcare provider) **Stamp/Seal:** **Date:** _____

Print Name: _____ **Phone:** _____