AUCC Immunization Form
Student Health and Wellness Center
455 Lee St SW, Suite 300 A, Atlanta, GA 30310
(404) 756-1241 shwcrequests@msm.edu
https://www.msm.edu/Current_Students/student-health/

Name: ____**DOB**: _____/_____/_______

Circle Your School: Morehouse School of Medicine Clark Atlanta University Morehouse College

Student ID#: ____________________ **School Email**: ___________________________ **Phone**: _________________

Address: ______________________________________ **City**: _____________ **State**: _____ **Zip Code**: _________

Instructions:

- This form **must** be completed by a healthcare provider and stamped by the office**. No exceptions.**
- Retain a copy of the completed form for your records.
- Scan this QR code for instructions on how to access your portal and upload the information.
- Upload a copy of this completed form to your Point and Click Patient Portal.

REQUIRED IMMUNIZATIONS

Required Immunizations	Date Administered (MM/DD/YYYY)	Required For
MMR (Measles, Mumps, and Rubella)	1st Dose ___/___/______ 2nd Dose ___/___/______ **OR** attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	Students born in 1957 or later and all foreign-born students, regardless of year born. If a titer is performed and does not indicate immunity a subsequent injection series is required. Antibody titer report must be submitted on lab letter head from a certified laboratory.
Varicella (Chicken Pox)	1st Dose ___/___/______ 2nd Dose ___/___/______ **OR** attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	All U.S. born citizens born in 1980 or later and all foreign-born students regardless of year born. If a titer is performed and does not indicate immunity a subsequent injection series is required. Antibody titer report must be submitted on lab letter head from a certified laboratory.
TDAP	Received within the last 10 years ___/___/_____	One dose of TDAP received within the last 10 years.

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Hepatitis B (check box below) ❑ 2 dose series ❑ 3 dose series ❑ Hep A – Hep B Twinrix	Either 2 dose series or 3 dose series 1st Dose ___/____/______ 2nd Dose ___/____/______ 3rd Dose ___/____/______ **OR** attached antibody titers **You do not need to submit antibody titers if you submit immunization records.	If a titer is performed and does not indicate immunity a subsequent injection series is required. Antibody titer report must be submitted on lab letter head from a certified laboratory.
Meningococcal MCV4/ Meningococcal ACWY/ Meningococcal Conjugate	One dose received on or after your 16th birthday. ___/____/_______	For all students 21 years old or younger and any student living in the dormitories. If your last dose was received >5 years ago, a booster dose is recommended. Please discuss with your health care provider. ❑ I attest that I am a graduate student living off campus.
Meningococcal B (check box below) ❑ 2 dose series Bexsero ❑ 3 dose series Trumenba	Either 2 dose series or 3 dose series 1st Dose ___/____/______ 2nd Dose ___/____/______ 3rd Dose ___/____/______	Required for individuals living in dorms/apartments and those younger than 23 years of age. Recommended for graduate students living off campus. ❑ I attest that I am a graduate student living off campus.
COVID-19 (check box below) ❑ Bivalent vaccine ❑ Updated Pfizer vaccine ❑ Updated Moderna Vaccine ❑ Novavax vaccine	Vaccine must have been given on or after 8/31/22 or later to be approved. 1st Dose___/____/______ 2nd Dose___/____/______	Requirement satisfied by either the bivalent COVID 19 vaccine, 1 dose of the updated Pfizer vaccine, 1 dose of the updated Moderna vaccine, or 2 doses of Novavax vaccine are required for approval. **Any vaccines given before 8/31/22 will not meet the requirement.**

Signature of Health Care Provider and Date Required
Name: Signature: Address: Phone Number: Date: Office Stamp Required

Revised: 1/31/2024

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Name: ________________________________

RECOMMENDED IMMUNIZATIONS

Recommended Vaccines	Date Administered (MM/DD/YYYY)	Recommended For
Hepatitis A (check box below) ❑ 2 dose series ❑ 3 dose series	Either 2 dose series or 3 dose series 1st Dose ___/____/______ 2nd Dose ___/____/______ 3rd Dose ___/____/______	Recommended for individuals with chronic liver disease, HIV infection, men who have sex with men, injection drug use, those working with Hepatitis A virus, who travel to countries with high prevalence countries, pregnancy, and settings for exposure.
Influenza Annually	Dose from most recent season ___/____/______	All individuals residing in dormitories or other group living situations, or who are members of athletic teams. Individuals with asthma, diabetes, or an immunodeficiency.
Human Papillomavirus (check box below) ❑ 2 dose series ❑ 3 dose series	Either 2 dose series or 3 dose series 1st Dose ___/____/______ 2nd Dose ___/____/______ 3rd Dose ___/____/______	Strongly recommended for all unvaccinated males and females through age 26.

Signature of Health Care Provider and Date Required
Name: Signature: Address: Phone Number: Date:

Office Stamp Required

Revised: 1/31/2024