James Madison University Immunization Form

COMMONWEALTH OF VIRGINIA LAW REQUIRES THAT THE **CERTIFICATE OF IMMUNIZATION AND TB ASSESSMENT FORM** BE COMPLETED AND SUBMITTED TO THE UNIVERSITY HEALTH CENTER. **An official immunization record from your doctor or another school will be accepted**

Instructions for new students:

1. Log onto MyJMUChart
   - **a.** Check the status of your immunizations under the Immunization tab. If your status is "Not Compliant" or "No Data" follow the instructions on the immunization page. If your status if "Verified" your record is complete.
   - b. Complete the TB Assessment for new incoming students under the Forms tab.
   - c. Enter your insurance information and upload a photo of your card under the Insurance tab.
   - d. If you are requested to submit immunization documentation, that can be done under the Upload tab.
2. Continue checking your JMU email and secure messages on MyJMUChart for confirmation that your record has been verified and is complete. Your pre-entry health requirements are not complete until you receive that confirmation.

Due dates for undergraduate students: July 6, 2024 for Fall 2024 semester start and January 5, 2025 for Spring 2025 start.

Due date for graduate students: No later than the third Friday of the first semester attending JMU.

An enrollment hold and a $50 fine will be placed on your account if your immunization form and TB Assessment Form are not deemed complete by the Health Center staff.

CERTIFICATE OF IMMUNIZATION*

This MUST be signed by a health care provider if this form is completed

Name (print): _____ **Date of Birth:** _____/_____/_____

Date completed: _____/_____/_____ **STUDENT ID NUMBER:** _____

REQUIRED IMMUNIZATIONS				
Tetanus, Diphtheria vaccine **Has Tdap ever been given to this patient? Yes No**	Date of most recent Tetanus containing vaccination (Must be within the past 10 years) **Date**: (MM/DD/YY) ____/____/____			
Hepatitis B ☐ **Combination Hepatitis A and B vaccine**	**Date**: (MM/DD/YY) 1) ___/___/___	**Date**: (MM/DD/YY) 2) ___/___/___	**Date**: (MM/DD/YY) 3) ___/___/____	**OR Titer (Attach Copy)**
Meningococcal Vaccine: Initial dose OR a booster dose must have been received on or after their 16th birthday	**Date**: (MM/DD/YY) 1) ___/___/___	**Date**: (MM/DD/YY) 2) ___/___/___	**If applicable, booster ≥ 16 years old** **Date**: (MM/DD/YY) ___/___/___	
Measles, Mumps, Rubella (MMR) Students born before 1957 are not required to have a second MMR vaccination. First dose AFTER 1st birthday	**Date**: (MM/DD/YY) 1) ___/___/___	**Date**: (MM/DD/YY) 2) ___/___/___	**OR Titer (Attach Copy)**	
TB Assessment Form	**Student must complete online form on MyJMUChart**			

STRONGLY RECOMMENDED BUT NOT REQUIRED				
COVID-19 (most recent vaccine)	**Date**: (MM/DD/YY) ___/___/___	**Influenza (most recent vaccine)**	**Date:**(MM/DD/YY) ___/___/___	
HPV (Quadrivalent or Bivalent)	**Date**: (MM/DD/YY) 1) ___/___/___	**Date**: (MM/DD/YY) 2) ___/___/___	**Date**: (MM/DD/YY) 3) ___/___/___	
Hepatitis A	**Date**: (MM/DD/YY) 1) ___/___/___	**Date**: (MM/DD/YY) 2) ___/___/___		
Meningococcal B Vaccine (__MenB-4C OR ___ MenB-FHpb)	**Date**: (MM/DD/YY) 1) ___/___/___	**Date**: (MM/DD/YY) 2) ___/___/___	**Date**: (MM/DD/YY) 3) ___/___/___	
Varicella ☐ **had** disease OR (2 doses one month apart for adults with no history of disease)	**Date**: (MM/DD/YY) 1) ___/___/___	**Date**: (MM/DD/YY) 2) ___/___/___	**OR Titer (Attach Copy)**	

This form will not be accepted if not signed by a health care provider.

HEALTH CARE PROVIDER SIGNATURE (Dr., Nurse, NP, PA, DO)

Printed Name _____ Phone _____

Address _____

Signature _____ Date _____