UNC Chapel Hill Immunization Form

Name: _____ Date of Birth:_____ UNC PID#: _____
(Last, First, Middle and/or Birth Name) (mm/dd/yyyy)

Preferred Name: _____ Phone:_____ Email:_____

Sex at Birth: ☐ Male ☐ Female ☐ Intersex/Ambiguous Pronouns: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Year & Semester Entering UNC: _____ ☐ Fall ☐ Spring Previously enrolled at UNC? ☐ No ☐ Yes - Year:_____

International Student? ☐ No ☐ Yes – Country of Origin: _____

Have your medical provider sign and date this form to verify all immunization dates entered **OR** you may attach a verified certificate of immunization with all required immunizations in lieu of a health care provider signature. **All records MUST be in English, or they will not be accepted**. Records must be uploaded through your To Do list item on your Connect Carolina Students Services Page. The general deadline is June 15th for fall admissions and December 15th for spring admissions. **Per North Carolina law, YOU WILL BE WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if immunization requirements have not been met.**

SECTION A – Required for ALL Incoming Students – provide all dates in MM/DD/YYYY format

MMR (Measles, Mumps, Rubella)

If born after 1956: either two (2) doses administered AFTER 1st birthday or positive serologic test required

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy

OR

Serologic test date: _____

Result:_____
(Must attach a copy of results)

Polio

If 17 years of age or younger when classes begin: three (3) doses required

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy
(#3) mm/dd/yyyy	

Meningococcal Conjugate Vaccine

*If born after 1/1/2003: one (*1) dose of Quadrivalent vaccine (ACYW) or Pentavalent (ABCWY) *given on or after age 16 is required. Meningococcal B vaccine does not meet this requirement.*

Vaccine name: _____

Date of Vaccine: _____
(must have been administered on or after the age of 16)

Diphtheria, Tetanus, and Pertussis

*At least three (3) doses are required - one of which **MUST** be a Tdap booster that was given on or after age 10. Exempt if previously attended college PRIOR to July 1, 2008*

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy
(#3) mm/dd/yyyy	(#4) mm/dd/yyyy

Tdap Booster Date: _____

☐ Exempt: Previously attended college prior to July 1, 2008.

Date entered:_____

Varicella (Chickenpox)

If born after April 1, 2001: either one (1) dose (2 is preferred), approximate age/date of disease, or positive serologic test is required.

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy

OR

Age/date of disease: _____

OR

Serologic test date: _____

Result: _____
(Must attach a copy of results)

Hepatitis B Vaccine

*If born after July 1, 1994: either the 3 dose series OR 2 dose HEPLISAV-B series accepted. ***Serologic test NOT accepted** – must show proof of vaccine dates.*

Three Dose Series

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy
(#3) mm/dd/yyyy	

OR

Two Dose Series (Heplisav-B)
(Only valid after November 2017)

(#1) mm/dd/yyyy	(#2 mm/dd/yyyy

(Continue on Reverse)

Questions? Email
immunizations@unc.edu

campus HEALTH

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Student Name: _____ UNC PID#:_____

SECTION B – Tuberculosis Testing – provide all dates in MM/DD/YYYY format

- TB Testing is **REQUIRED** for students from countries with an increased incidence of Tuberculosis (TB).
  - Must provide documentation of TB testing which was performed within one year prior to matriculation.
  - Acceptable tests include either an IGRA Blood Test (usually acceptable from home country; report must contain student demographic information and results must be in English) or a TB skin test performed in the United States.
  - Campus Health may recommend additional TB screening with a Campus Health provider after review of records submitted.
- TB testing is **RECOMMENDED** for students who have risk factors that increase their likelihood of exposure to tuberculosis (TB).
- See https://campushealth.unc.edu/services/immunizations/tb-information for list of countries and more information regarding risk factors.

IGRA Blood Test (QuantiFERON or T-SPOT)

Must attach a copy of laboratory results

Date of Test mm/dd/yyyy	Result of Test
	☐ Positive ☐ Negative

Tuberculin Skin Test (TST)

Must have been performed in the United States in the last year

Date Placed mm/dd/yyyy	Date Read mm/dd/yyyy	Result (mm induration)

SECTION C – Recommended Immunizations (NOT REQUIRED) – provide all dates in MM/DD/YYYY format

Human Papillomavirus (HPV)

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy	(#3) mm/dd/yyyy

Vaccine name:_____

Meningococcal B Vaccine

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy	(#3) mm/dd/yyyy

Vaccine name:_____

Pneumococcal Vaccine

(e.g., PCV13, PCV15,PCV20, PCV21,PPSV23)

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy

Vaccine name: _____

Hepatitis A Series

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy

_____ _____

Signature and Credentials of Health Care Provider Date

_____ _____

Printed Name and Credentials of Health Care Provider Office Phone Number

_____ _____

Office Address City State Zip Code