Wake Forest University Health Information & Immunization Documentation Instructions

2024-25 Academic Year

North Carolina General Statute §130A 152-157 requires that ALL students entering college present a certificate of immunization which documents that the student has received the immunizations that are required by law. This documentation must be signed by a healthcare provider and include an office address. Students may be withdrawn from the university 30 days after classes begin if the mandatory immunization and TB requirements have not been met.

Deadlines for submission of all pages:
Fall admission – July 1
Spring admission – January 1
Summer admission – May 1

Basic Instructions:

- All Immunization records are required to be submitted in, or translated into English, and in MM/DD/YYYY format.
- Include name and Wake ID number on all forms.
- Forms completed at a doctor's office, clinic or health department must contain an "official Stamp" and/or clinician signature for documents to be complete and accepted.
- KEEP A COPY FOR YOUR RECORDS.

The following steps are MANDATORY:

1. Have a doctor's office, clinic or health department complete the Immunization Form.
2. Complete the Tuberculosis Questionnaire - all incoming students must be screened for Tuberculosis risk factors through a screening questionnaire
3. The completed Immunization Requirements Form and TB Screening Questionnaire must be uploaded to your Deacon Health Portal.

Acceptable records of your immunizations may be obtained from any of the following:

- Personal shot records: Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- High School Records: These may contain some, but not all of your immunization records. Your immunization records do not transfer automatically. You must request a copy.
- Local Health Department
- Previous College or University Records: Your immunization records do not transfer automatically. You must request to have a copy sent to our immunizations department. Records must include clinic address.
- Military Records or WHO (World Health Organization) Documents: These records may not contain all of the required immunizations.

IMPORTANT! Your information will be reviewed by staff. You will be notified via email or Deacon Health Portal secure message if additional information is needed. Keep a copy for your records. There are occasions when you may need to resubmit your documentation.

CONFIDENTIALITY: Student medical records are confidential. Medical records and information contained in the records may be shared with therapists and physicians who are involved in the student's care, and otherwise will not be released without the student's permission except as allowed by law. Students who wish to have their medical records or information released to other parties should complete a release of information form at the time of each office visit or service.

Authorization to Treat Form

To be completed by student (use black ink if by hand)

Last Name	First Name	Middle Initial	Preferred Name	Date of Birth	WFU ID #

Permanent Address:_____

Cell Phone:_____ Email Address:_____

Sex assigned at birth: Female ☐ Male ☐ Intersex ☐ Marital status: Single ☐ Married ☐ Domestic Partner ☐

Class you are entering: Fr. ☐ Soph. ☐ Jr. ☐ Sr. ☐
Graduate School of Arts & Sciences ☐ School of Business Graduate School ☐
School of Law ☐ School of Divinity ☐

Semester entering: ☐ Fall 20_____ ☐ Spring 20_____ ☐ Summer 20_____

Will you be participating on a NCAA athletic team? Yes ☐ No ☐ If so, which sport?_____

In case of emergency, contact:

Name:_____ Relationship: _____

Cell Phone:_____ Home Phone: _____ Bus. Phone: _____

Address: _____ City/State: _____

Zip:_____ Email:_____

Important Information—Please read and sign below:

Authorization and Consent: If the student is under the age of 18, a parent or guardian must also sign. I agree that the attending physician or whomever he or she may designate may evaluate and treat all injuries or illnesses for which help is sought. In the case of a minor student, (under the age of 18) this treatment may proceed without prior notification of the undersigned parent or guardian. I also agree that needed immunizations may be administered. I further agree that Deacon Health may release any medical information to other health care providers who are involved in my care.

_____ Date_____/_____/_____

Signature of Student (must be printed and signed)

_____ Date_____/_____ /_____

Signature of Parent/Guardian, if student under age 18

Once completed: upload a clear image of this finalized Authorization to Treat form and a copy of your current insurance card* to the Deacon Health Portal at deaconhealth.wfu.edu/portal.

*Deacon Health does not file claims or accept insurance payments. Card will be on file for assistance in referrals to office campus resources.

Wake Forest University Medical History Form

Last Name	First Name	Middle Initial	Preferred Name	Date of Birth	WFU ID #

Family History

	Age	State of Health	Occupation	Age of Death	Cause of Death
Parent					
Parent					
Brother(s)					
Sister(s)					

Have any of your relatives ever had any of the following? Check yes where applicable.

Condition	Yes	Relationship
Blood Clots (lung or leg)		
Asthma		
Cancer (type)		
Diabetes		
Heart disease		
Hereditary disease		
High blood pressure		
Migraine headaches		
Are you adopted?		

Personal History (check all that apply)

Are you allergic to:

Bees, wasps	
Peanuts	
Penicillin	
Sulfonamides	
Other medications/foods	
Specify	
Do you receive allergy injections?	

Have you had:

Anemia	
Asthma	
Cancer	
Corrective lenses	
Chronic medical condition	
Concussion	
Diabetes Type 1	
Diabetes Type 2	
Heart disease	

Have you had:

Hepatitis B	
Hepatitis C	
High blood pressure	
HIV	
Kidney disease	
Menstrual cycle disorders	
Migraines or chronic headaches	
Mobility disorder	
Neurological disorder	
Other endocrine disorders	
Organ loss	
Respiratory disorder	
Seizures	
Serious head injury	
Sexually transmitted infections	
Stomach or intestinal disorders	
Surgery or serious injury	

Have you had:

Smoking/tobacco use	
Thyroid disease	
Vision problems	

Other Mental Health Conditions

ADD, ADHD	
Anxiety	
Alcohol abuse problems	
Depression	
Diagnosed learning disorder	
Eating disorder	
Other drug use problems	
Victim of personal or sexual assault	

Tuberculosis Screening Questionnaire

Last Name	First Name	Middle Initial	Preferred Name	Date of Birth	WFU ID #

	Yes	No
1. Have you ever lived with or been in close contact with a person known or suspected of being sick with TB?		
2. Have you been a resident, volunteer and/or an employee of a congregate living facility? (correctional facility, long term health care facility or homeless shelter)		
3. In the last 12 months have you lived, worked or visited for more than 1 month in one of the following countries listed?		

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Côte d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

- Wake Forest University requires TB testing to be complete within three (3) months of arriving on campus.
- If the answer to all of the above questions is NO: No further action is needed.
- If the answer to any one of the above questions is YES: Proof of testing must be uploaded to your Deacon Health Portal for review.

TB testing must be in the form of IGRA Blood Test and be administered no more than 6 months prior to arrival at Wake Forest.

A PPD, T-Spot and Chest x-ray are NOT accepted as a form of TB testing.

Once completed: upload a clear image of this finalized Tuberculosis Screening Form to the Deacon Health Portal at deaconhealth.wfu.edu/portal.

Immunization Documentation Information

IMPORTANT: The immunization requirements must be met or according to NC law, you will be withdrawn from classes without credit.

Be certain that your Name, Date of Birth and Student ID Number appear on each sheet where requested and that all forms are sent together. The records must have the vaccine administration dates. The dates MUST include the month, day, and the year. Acceptable Records of your immunizations may be obtained from any of the following:

- Personal Shot Records / Local Health Department: Must be verified by a doctor's stamp or signature, or by a clinic or health department stamp with address.
- Military Records or WHO (World Health Organization) Documents: These records may not contain all of the required immunizations. Required records within these documents are however accepted. Must have the clinic address.
- Previous College or University Records: Your immunization records do not transfer automatically. You must request to have a copy sent to our immunizations department. Records must include clinic address.

For information regarding medical or religious exemption requests, visit deaconhealth.wfu.edu

College / University Vaccines and Number of Dose (Booster) Requirements

VACCINE	# DOSES/BOOSTER REQUIRED BEFORE SCHOOL ENTRY*
Diphtheria, tetanus and pertussis[1]	3 doses
Polio[2]	3 doses
Measles[3]	2 doses
Mumps[4]	2 doses
Rubella[5]	1 dose
Hepatitis B (Hep B)[6]	3 doses
Varicella[7]	2 doses
Meningococcal: Quadrivalent ACYW-135[8]	1 dose (on or after 16th birthday)
COVID-19[9]	2 dose or 3 doses

1) Three doses are required for individuals entering college or university. Individuals entering college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid; one of which must be tetanus/diphtheria/pertussis. Given since 2005.
2) Three doses are required for individuals entering college or university. An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.
3) Two doses at least 28 days apart are required for individuals entering college or university. The requirement for a second dose does not apply to individuals who entered school, college, or university for the first time before July 1, 1994. A person who has been diagnosed prior to January 1, 1994 by a physician (or designee such as a nurse practitioner or physician's assistant) as having measles (rubella) or an individual who has been documented by serological testing to have a protective antibody titer against measles is not required to receive measles vaccine. Individuals born before 1957 are not required to receive a measles vaccine except in measles outbreak situations.
4) Two doses are required for individuals entering college or university. A physician's diagnosis is not acceptable for mumps disease(s). Individuals must be immunized or have laboratory confirmation of disease or have been documented by serological testing to have a protective antibody against mumps. Individuals born before 1957 are not required to receive the mumps vaccine. Individuals that entered college or university before July 1, 1994 are not required to receive the vaccine. Individu-als that entered school, college, or university before July 1, 2008 are not required to receive the second dose of mumps vaccine.
5) One dose is required for individuals entering college or university. A physician's diagnosis is not acceptable for rubella disease(s). Individuals must be immunized or have laboratory confirmation of rubella disease or have been documented by serological testing to have a protective antibody titer against rubella. Any individual who has attained his or her fiftieth birthday is not required to receive rubella vaccine except in outbreak situations. Any individual who entered college or university after his or her thirtieth birthday and before February 1, 1989 is not required to receive rubella vaccine except in outbreak situations.
6) Three doses are required for individuals entering college or university. Hepatitis B vaccine is not required if an individual was born before July 1, 1994.
7) Varicella is not required if an individual was born before April 1, 2001.
8) Meningococcal Quadrivalent ACYW-135 is required of all undergraduate students. One dose on or after the 16th birthday. Recommended for graduate and professional students. Learn about this disease at https://www.immunize.nc.gov/family/vaccines/meningococcal.htm.
9) The University continually reviews protocols and recommendations based on the available data and advice of public health experts and will make updates in future semesters, if needed. Current requirement: Primary vaccine and booster. The booster must be an mRNA.

* Must repeat Rubeola (measles) vaccine if received more than 4 days prior to 12 months of age. History of physician - diagnosed measles disease is acceptable, but must have a signed statement from physician.
**Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician is not acceptable.
***Vaccine, laboratory proof of immunity, or history of disease with a signed physician statement is acceptable to varicella.

Immunization Form

Last Name	First Name	Middle Initial	Preferred Name	Date of Birth	WFU ID #

Section A: Required Immunizations						
Immunization Name		Date(s) Administered (MM/DD/YY)				
Students must submit documentation of 3 DTP, Td, or Tdap vaccines regardless of age. One MUST be a Tdap, one must be within the past 10 years. DTaP/DTP/Td (diphthe-ria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid)	Dtap					
	Dtp					
	Td					
Tdap Booster (All students MUST show proof of a Tdap booster)						
Polio (3 doses required for students under 18 years of age)						
MMR (Measles, Mumps, Rubella - 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps, and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers)						
Measles (2 required on or after first birthday OR positive titer OR documented disease date)					Disease Date	**Titer Date & Result
Mumps (2 required on or after first birthday OR positive titer)					*Disease Date not accepted*	**Titer Date & Result
Rubella (1 required on or after first birthday OR positive titer)					*Disease date not accepted*	**Titer Date & Result
Hepatitis B Series (required if born on or after July 1, 1994)						*Titer NOT Accepted for required Hep B Series*
Varicella (2 doses required if born on or after April 1, 2001. Positive titer OR date of disease is acceptable)					Disease Date	**Titer Date & Result
Meningococcal Quadrivalent ACYW-135 (Men-actra, Menveo) A dose is required ≥ age 16 years for all undergrad-uates. Meningococcal B vaccine DOES NOT fulfill this requirement. Recommended for graduate/professional students through age 21.						
Section B: Strongly Recommended						
Immunization Name						
COVID-19	Type	Dates Administered (MM/DD/YY)				
The University continually reviews protocols and recommendations based on the available data and advice of public health experts and will make updates in future semesters, if needed.	Moderna					
	Pfizer					
	J&J Janssen					
Seasonal Influenza Vaccine						

Section C: Recommended Immunizations					
Immunization Name		Date(s) Administered (MM/DD/YY)			
Hepatitis A					
Human Papillomavirus (HPV)	Cervarix				
	Gardasil				
	Gardasil-9				

Section D: Recommended Immunizations for Certain Patients/Medical Conditions					
Immunization Name		Date(s) Administered (MM/DD/YY)			
Meningococcal Group B	Trumenba				
	Bexsero				
Pneumovax					
Yellow Fever					
Typhoid IM					
Typhoid Oral					
Other					

Healthcare Provider Information & Signature:

Name (print): _____ Date: _____

Office Address: _____

Phone: _____

Are you the student's primary care provider? ☐ Yes ☐ No If no, how long have you known the student?_____

Signature: _____