**Immunization and Tuberculosis Screening Requirement**

**Northwestern University in Qatar (NU-Q) requires all students to submit documentation of vaccination or immunity from Polio, Diphtheria, Tetanus, Hepatitis B, Measles, Mumps, Rubella, Varicella, and Meningitis and documentation of a Tuberculosis (TB) skin test within the last year using the *Immunization and Tuberculosis Screening Certificate* to the NU-Q Counseling and Wellness Office by June 15, 2014.  Noncompliance to the immunization and tuberculosis screening requirement will result in a student record hold, which will prevent registration for classes.**

Related to health and wellness is the matter of obtaining and recording the immunizations and vaccines you have had over the years. NU-Q respectfully requests that you complete the enclosed Immunization and Tuberculosis Screening Certificate. Your compliance with the requirements ensures your registration for classes as well as on-campus residency privileges, if applicable. You will be able to complete page one on your own, but you will need to make an appointment with your physician to discuss the status of your immunizations and to complete page 2-3.

After you and your physician have completed the Certificate, please return it to the Counseling and Wellness Office on or before June 15, 2014. In order to avoid a hold on your record, please begin the process of meeting with your doctor to discuss your immunization status as soon as possible.

You may submit your documentation to the Counseling and Wellness Office located in the NU-QStudent Affairs suite, of the Carnegie Mellon Building, room 3088. If you so choose, you may also submit your documentation via email as an attachment to [patricia.collins@northwestern.edu](mailto:patricia.collins@northwestern.edu). Please be aware that email is not completely secure.

Please contact the Department of Student Affairs if you have any questions by emailing [patricia.collins@northwestern.edu](mailto:patricia.collins@northwestern.edu).

****IMPORTANT: Read the following information in its entirety and submit all information in English.

Northwestern University in Qatar (NU-Q) requires all students at the time of registration provide documentation of vaccination for or immunity from Polio, Diphtheria, Tetanus, Hepatitis B, Measles, Mumps, Rubella, Varicella, and Meningitis by a healthcare provider (licensed M.D. or D.O, or Licensed Nurse). 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 be vaccinated for Hepatitis A, Typhoid, and HPV. 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](http://www.hmc.org.qa/hmcnewsite/immunization.aspx). ***This certificate must be returned to the Counseling and Wellness Office by June 15, 2014. Failure to comply with this requirement will result in a student record hold.*** 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 applicable), and Section 3 to be completed, signed and stamped by healthcare provider. If you have any questions, please contact the Counseling and Wellness Office. Keep a copy of this form for your records and return the original to: NU-Q Counseling and Wellness Office.

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

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM DD YYYY

Gender: Male / Female Marital Status: Single / Married Blood Type: \_\_\_\_\_\_\_\_\_\_\_ Qatar ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Local Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health issues about which you would like NU-Q Counseling and Wellness to know: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 form*.  
Section 2. Treatment/Sharing of medical information of minors (under age 18 years)**As the parent/guardian of my minor (under 18 years of age) son or daughter, I hereby authorize 1) the sharing/exchange of relevant medical information between NU-Q representatives and medical providers for the purpose of diagnosis/treatment; 2) the transportation of my minor child, under appropriate circumstances, to area hospitals for diagnosis/treatment; and 3) the provision, by Counseling and Wellness Service, of such diagnostic and therapeutic procedures as may be deemed necessary. Any and all related expenses will be the responsibility of the student and/or parent/guardian.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of parent/legal guardian*

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **.**

*Printed name of parent/legal guardian*

**Section 3. Healthcare Record: To be completed by a healthcare provider**A. Required immunizations.Record the dates of vaccinations. If using lab results showing positive immunity, they MUST BE ATTACHED. Please mark the box indicating that lab results showing positive immunity have been attached for that particular illness. Some immunizations require a series of shots. Only those shots which are not yet due will be allowed to be incomplete at this time. However, the student will be required to complete all shots when they are due to remain compliant with the immunization requirements and to continue his/her enrollment.

***COMPLETE ALL THREE (3) PAGES OF THIS DOCUMENT***



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| --- | --- |
| Please document at least 2 dates from the primary series (done in childhood) TETANUS/DIPHTHERIA SERIES - (Td, DT, DTP, DTaP or Tdap meet the requirement) • Doses MUST be at least 28 days apart. | Date: \_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  MM DD YYYY Date: \_\_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_   MM DD YYYY |

1. Last Polio: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_ ***OR***Adult Booster: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_ MM DD YYYY MM DD YYYY  
***\*\*\*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) must be within 10 years prior to entrance to university. \*\*\*   
Tetanus/Diphtheria (Td):\_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_ ***OR*** Tetanus/Diphtheria/Pertussis (Tdap): \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_  
 MM DD YYYY MM DD YYYY  
3. Measles/Mumps/Rubella ***OR*** If given separately, complete this section: **\*\*\*1st dose must be after 12 months of age.   
2 doses required (at least 28 days apart). \*\*\***MMR #1: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_ **.** Measles #1: \_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_ Measles #2: \_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_ MM DD YYYY MM DD YYYY MM DD YYYY

MMR #2: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_Mumps #1: \_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_ Mumps #2 \_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_

MM DD YYYY MM DD YYYY MM DD YYYY

Rubella #1: \_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_ Rubella #2 \_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_

MM DD YYYY 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**

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4. Hepatitis B #1: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_ ***OR*  Attached lab report showing positive immunity to Hepatitis B**

MM DD YYYY

Hepatitis B #2: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_ .

MM DD YYYY

Hepatitis B #3: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_ .

MM DD YYYY



5. Varicella #1: : \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_ **. *OR*  Attached lab report showing positive immunity to Varicella**

MM DD YYYY

Varicella #2: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_\_\_\_\_

MM DD YYYY



6. Meningococcal: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_   
 MM DD YYYY

****B. Required Tuberculosis (TB) screening. A PPD-Mantoux test must be placed and interpreted by a healthcare provider within 12 months prior to registration.   
PPD placed: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_. PPD read: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_ Result in mm in duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 MM DD YYYY MM DD YYYY

**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: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X-Ray: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM DD YYYY MM DD YYYY  
Medical Diagnosis: \_\_\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_ **Result: \_\_\_\_\_ TB POSITIVE \_\_\_\_\_*OR \_*\_\_\_\_  TB NEGATIVE**  
 MM DD YYYY  
 ***COMPLETE ALL THREE (3) PAGES OF THIS DOCUMENT***



C. Recommended Immunizations.

The following vaccinations, while not required, are recommended

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

1. Hepatitis A: \_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_ 2. Typhoid\_\_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_ 3. Human Papillomavirus (HPV) \_\_\_\_/\_\_ \_\_/\_\_\_\_\_\_

MM DD YYYY MM DD YYYY MM DD YYYY

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of healthcare provider REQUIRED**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stamp/Seal:**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**