Please mail/fax to:

University of Delaware-Student Health Services
282 The Green, Laurel Hall, Newark, Delaware 19716-8101
Telephone: 302/831-2226—Fax: 302/831-6407

ELI - IMMUNIZATION DOCUMENTATION

Not to be used for Academic Transition (AT) Students

ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PRACTITIONER.

Please include a copy of the FRONT and BACK of your Medical Insurance Card and Prescription Insurance Card.

Must be completed in English. All dates in Western/Gregorian calendar.

Student Name_____
Last First Middle

Date of Birth_____ UD ID #_____
Month Day Year

Country of Birth_____ If **not** USA, indicate when you entered this country_____
MM/YYYY

PARENTAL/GUARDIAN PERMIT (FOR STUDENTS UNDER AGE 18) I give my permission for medical care and procedures as may be deemed necessary for my student and agree to present information concerning his/her medical condition to other responsible university officials when deemed necessary. I give permission to bill for any medical care performed.

Signed_____ Relationship_____

IF THIS FORM IS NOT COMPLETE, YOU WILL NOT BE PERMITTED TO REGISTER FOR THE NEXT SESSION.

1. REQUIRED - *ALL* STUDENTS BORN AFTER 1956

MMR (Measles, Mumps, Rubella) (Two doses required **after 12 months** of age and at least 28 days apart.)

MMR Dates **#1**____/____/____, **#2**____/____/____ **/OR**
M D Y M D Y

Measles Dates ___/___/___, ___/___/___ /or Antibody Titer Date ___/___/___ *
M D Y M D Y M D Y

Mumps Dates ___/___/___, ___/___/___ /or Antibody Titer Date ___/___/___ *
M D Y M D Y M D Y

Rubella Dates ___/___/___, ___/___/___ /or Antibody Titer Date ___/___/___ *
M D Y M D Y M D Y

*** Must enclose copy of lab report**

See reverse side of form for additional immunization history, religious/medical exemption, and practitioner's signature.

2. REQUIRED INFORMATION - *ALL* STUDENTS

2A - TUBERCULOSIS (TB) RISK QUESTIONNAIRE

1. Have you ever had a positive tuberculosis skin test or blood test in the past? ☐ Yes ☐ No
2. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)? ☐ Yes ☐ No
3. Were you born in a country listed below? * ☐ Yes ☐ No
4. Have you traveled or lived for more than one month in any country listed below? * ☐ Yes ☐ No
5. Have you ever had changes on a prior chest x-ray suggesting inactive or past TB disease? ☐ Yes ☐ No
6. Do you have a medical condition associated with increased risk of progressing to TB disease if infected, such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, HIV/AIDS, gastrectomy or intestinal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone >15mg/day for > 1 month), other immunosuppressive disorders, or are you an organ transplant recipient ? ☐ Yes ☐ No
7. Have you been a volunteer, employee or resident in a high-risk congregate setting such as a prison, nursing home, hospital, homeless shelter, residential facility or other health care facility in the past 12 months? ☐ Yes ☐ No
8. Do you have a history of illicit drug use? ☐ Yes ☐ No

* Angola, Bangladesh, Brazil, Central African Republic, China, Congo, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, Ukraine, UR Tanzania, Viet Nam, Zambia, Zimbabwe

2B - If you answer NO to all of the above questions, no further action is required. If you answer YES to any of the above questions, you are required to have a Mantoux tuberculin skin test (TST) or TB Blood Test (IGRA), *within 6 months prior to beginning classes*. *Prior BCG does not exempt students from this requirement.* If your TST or TB Blood Test is positive please attach chest x-ray results that were completed in the USA. All TB testing must be the same day or 28 days after any live vaccines.

2C - TB SKIN TEST Use Mantoux test only **-OR- TB BLOOD TEST**

Date Planted: ___/___/___ (M D Y)

Date Read: ___/___/___ (M D Y)

Interpretation: Neg. ☐ Pos. ☐

_____mm induration

(If no induration, mark "0")

Quantiferon: ☐ *

T-Spot: ☐ *

Date : ___/___/___ (M D Y)

Result: Neg. ☐ Pos. ☐

*Enclose copy of lab report

2D - CHEST X-RAY*

Chest X-Ray Date : ___/___/___ (M D Y)

☐ Normal ☐ Abnormal

*Enclose copy of USA x-ray report

2E - MEDICATION TREATMENT FOR TB:

Drug: _____

Dose and Frequency: _____

Treatment:
Start Date ___/___/___ (M D Y)

End Date ___/___/___ (M D Y)

A PHYSICAL EXAMINATION IS *NOT* REQUIRED. • ALL INFORMATION MUST BE IN ENGLISH. • PLEASE PRINT.

Health Care Practitioner Signature (Physician, Nurse Practitioner, P.A., Nurse)

Name _____ Address _____
(Print Clearly)

Signature _____ Date _____ Phone (_____) _____

Immunization Exemptions: A signed letter is required for religious exemption. A healthcare practitioner's signed letter is required for medical exemption.