IMMUNIZATION DOCUMENTATION

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

THIS FORM MUST BE SUBMITTED BY JULY 25 FOR FALL SEMESTER AND JANUARY 25 FOR SPRING SEMESTER

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

This does not satisfy the required online insurance waiver for full-time students.

Student Name ________________________________

Date of Birth __________________________

Country of Birth __________________________

If not USA, indicate when you entered this country ________________________

PARENTAL/GUARDIAN PERMIT (FOR STUDENTS UNDER AGE 18) I give my permission for such diagnostic and therapeutic 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.

Signed ________________________________ Relationship ________________________________

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

1. REQUIRED - ALL STUDENTS BORN AFTER 1956

MMR (Measles, Mumps, Rubella) (Two doses required after 12 months of age.)

MMR Dates #1 / / / or #2 / / / / OR

Measles Dates / / / or Antibody Titer Date / / *

Mumps Dates / / / or Antibody Titer Date / / *

Rubella Dates / / / or Antibody Titer Date / / *

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 and arrived in the U.S. within the past 5 years? * □ 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, Azerbaijan, Bangladesh, Belarus, Brazil, Botswana, Cambodia, Cameroon, Central African Republic, Chad, China, Congo, DPR Korea, DR Congo, Ethiopia, Ghana, Guinea-Bissau, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Lesotho, Liberia, Malawi, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Peru, Philippines, Republic of Moldova, Russian Federation, Sierra Leone, Somalia, South Africa, Swaziland, Tajikistan, Thailand, Uganda, Ukraine, UR Tanzania, Uzbekistan, 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 of beginning classes. Prior BCG does not exempt students from the requirement. If TST or TB Blood Test is positive please attach chest x-ray results that were completed in the USA.

2C - TB SKIN TEST Use Mantoux test only

Date Planted: / / / Interpretation:Neg. □ Pos. □ mm induration

Date Read: / / /

(If no induration, mark “0”)

3D - CHEST X-RAY* Chest X-Ray Date:

/ / /

Normal □ Abnormal

Result: Neg. □ Pos. □

*Enclose copy of USA x-ray report

2E - MEDICATION TREATMENT FOR TB:

Drug:

Dose and Frequency:

Treatment:

Start Date / / /

End Date / / /

*Enclose copy of USA x-ray report

See reverse side for form additional immunization history, religious/medical exemption and practitioner’s signature.
**MENINGOCOCCAL VACCINE INFORMATION**

The Disease: Meningococcal disease is a serious illness caused by a bacterium. Meningococcal bacteria live in the lining of the nose and throat and can be spread from one person to another by close personal contact and severe disease. Occasionally, the bacteria enter the bloodstream and cause severe meningococcal disease. Meningococcal disease can be rapidly fatal and can kill an otherwise healthy young person in 48 hours or less.

**Recommended Immunizations**

- All 11 to 12 year olds should be vaccinated with a single dose of quadrivalent (protects against serogroups A, C, W, and Y) meningococcal conjugate vaccine.
- Since protection wanes, a booster dose is recommended at age 16 years so adolescents continue to have protection during the ages when they are at highest risk of meningococcal disease.
- First-year college students living in residence halls are recommended to be vaccinated with meningococcal conjugate vaccine. If they received this vaccine before their 16th birthday, they should get a booster dose before going to college for maximum protection.

**RECOMMENDED IMMUNIZATIONS**

- TETANUS-DIPHTHERIA-PERTUSSIS
  
- PPD
  
- Varicella
  
- Mumps
  
- Measles
  
- Rubella
  
- Hepatitis A
  
- Hepatitis B
  
- Polio
  
- Tdap Booster within the last 10 years

**CDC Recommendations**

All 11 to 12 year olds should be vaccinated with a single dose of quadrivalent (protects against serogroups A, C, W, and Y) meningococcal conjugate vaccine.

Since protection wanes, a booster dose is recommended at age 16 years so adolescents continue to have protection during the ages when they are at highest risk of meningococcal disease.

First-year college students living in residence halls are recommended to be vaccinated with meningococcal conjugate vaccine. If they received this vaccine before their 16th birthday, they should get a booster dose before going to college for maximum protection.

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

Name ___________________________________________ Address ___________________________________________

Signature ___________________________________________ Date ___________ Phone (___________)

*Immunization Exemptions: Notarized letter required from clergy for religious, or from physician for medical (attach to form)*

**Antibody Titer Date:_____/_____/_____, Result: Reactive___Non Reactive___**

**Enclose Copy of Lab Report**

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