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

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_____
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 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____/____/____, #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**

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 **-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: ☐ *
Other:_____
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

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

REQUIRED VACCINE - ALL STUDENTS

MENINGOCOCCAL MENINGITIS VACCINE*

☐ Menactra® Vaccine Dates (conjugate) #1____/____/____, #2____/____/____ (M D Y M D Y)

☐ Menveo® Vaccine Dates (conjugate) #1____/____/____, #2____/____/____ (M D Y M D Y)

☐ Menomune® Vaccine Dates (polysaccharide) #1____/____/____, #2____/____/____ (M D Y M D Y)

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.

MENINGOCOCCAL VACCINE INFORMATION

The Disease: Meningococcal disease is a serious illness caused by a bacteria. Meningococcal bacteria live in the lining of the nose and throat and can be spread from one person to another by close personal contact. Occasionally, the bacteria enter the bloodstream and cause severe disease. Symptoms of bloodstream infection include fever, chills, rash, low blood pressure and dark purple spots on the arms and legs. Meningitis is an infection of the lining of the brain and spinal cord. Symptoms of meningitis include fever, headache, confusion and stiff neck. Five different types of meningococcal bacteria cause virtually all meningococcal disease: A, B, C, Y and W-135. Every year in the United States approximately 3,000 people are infected with meningococcus and approximately 10%-15% of these people die from the disease. Of those who live, another 11 - 19% have permanent disabilities such as loss of limbs, kidney disease, hearing loss, or they may suffer seizures or strokes. Meningococcal disease can progress very rapidly and can kill an otherwise healthy young person in 48 hours or less. **The Vaccines:** The Menomune® meningitis vaccine first became available in the United States in 1982. It is effective against four of the five different types of meningococcus (A, C, Y and W-135), and if indications still exist a booster dose may be considered within 3 to 5 years. In February 2005, the Center for Disease Control (CDC) recommended a new vaccine for use in the United States to prevent meningococcal disease. This conjugate meningitis vaccine, called Menactra®, protects against the same four types of meningococcal bacteria as the Menomune® vaccine and should provide longer protection. Menactra® should also be better at preventing the disease from spreading from person to person. The newest vaccine approved in February 2010, Menveo®, is also a conjugate vaccine effective against groups A, C, Y and W-135. All three vaccines work well, and protect about 90% of those who receive it. None of these vaccines provide 100% protection nor do they protect against meningococcus type B meningococcal bacteria. Additional Considerations For College Students : All college freshmen, especially students living in dormitories, should consider receiving the meningococcal vaccine. College freshmen living in dormitories are five times more likely to get meningococcal disease than people of the same age who do not attend college. College students who are at higher risk for meningococcal disease because of underlying immune deficiencies or who are traveling to countries where outbreaks or epidemics of meningococcal meningitis often occur, such as the sub-Saharan belt in Africa, should be vaccinated. Individuals who are routinely exposed to meningococcal bacteria in a laboratory setting should also consider getting the vaccine. **Sources:** ACIP (Advisory Committee on Immunization Practices) of the CDC (Center for Disease Control); Vaccines: What You Should Know, Paul A. Offit, M.D., and Louis M. Bell, M.D.

RECOMMENDED IMMUNIZATIONS

TETANUS-DIPHTHERIA-PERTUSSIS

☐ Completed primary series of tetanus-diphtheria-pertussis immunizations ..... ____/____/____ (M D Y)

☐ Td ..... ____/____/____ (M D Y)

☐ Tdap Booster within the last 10 years ..... ____/____/____ (M D Y)

POLIO (POLIOMYELITIS)

☐ Completed primary series of polio immunization Date ____/____/____, Last Booster ____/____/____ (M D Y)

HEPATITIS A Dates #1____/____/____, #2____/____/____ (M D Y M D Y)

HEPATITIS B Dates #1____/____/____, #2____/____/____, #3____/____/____ (M D Y M D Y M D Y) ***OR***

HEPATITIS B surface antibody Result: Reactive___Non Reactive___ ____/____/____ (M D Y) *Enclose Copy of Lab Report

COMBINED HEPATITIS A and B VACCINE Dates #1____/____/____, #2____/____/____, #3____/____/____ (M D Y M D Y M D Y)

HPV ☐ Gardasil® Dates #1____/____/____, #2____/____/____, #3____/____/____ (M D Y M D Y M D Y)

VARICELLA (Chicken Pox) #1____/____/____, #2____/____/____ / or Disease Date ____/____ (M D Y M D Y M Y) ***OR***

Antibody Titer Date:____/____/____ (M D Y) Result: Reactive___Non Reactive___ *Enclose Copy of Lab Report

MENINGITIS B VACCINE: Trumenba #1____/____/____, #2____/____/____, #3____/____/____ (M D Y M D Y M D Y)

Bexsero #1____/____/____, #2____/____/____ (M D Y M D Y)

OTHER _____ Date ____/____/____ (M D Y) **OTHER** _____ 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 _____ (Print Clearly) Address _____

Signature _____ Date _____ Phone (_____) _____

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