

**Indiana State University
Student Health Center - Immunization Record**

Name: _____
Last
First
Middle

Date of Birth: ____/____/____ ISU ID # _____
Mo
Day
Yr

PART A: WE PREFER THIS FORM BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. IF NOT COMPLETED BY YOUR HEALTH CARE PROVIDER YOU MUST PROVIDE (a) a physician's certificate, if available; (b) immunization records forwarded from another school or postsecondary institution; (c) a record maintained by the student or parent of the student showing the month, day, and year during which each dose of vaccine was administered; (d) a form developed by the department which may be used by postsecondary institutions to meet the requirements of this chapter; (e) evidence of having met alternative criteria. **Enter all information in English.**

I. **REQUIRED** FOR ALL STUDENTS (*starred items required only if born in 1957 or later, first dose must be after first birthday and after 1967) Registration for next semester will be blocked if all available immunizations are not up to date

A. TETANUS-DIPHTHERIA

Tetanus-Diphtheria booster must be within the last 10 years.....____/____/____
Mo
Day
Yr

B. *MMR (MEASLES, MUMPS, RUBELLA)

Two doses required, at least one month apart.....Dose #1 ____/____/____ Dose #2 ____/____/____
Mo
Day
Yr
Mo
Day
Yr

OR ALL 3 OF THE FOLLOWING CRITERIA MUST BE MET:

*MEASLES (RUBEOLA)

- Has report of positive immune **titer**. Specify date: ____/____/____ **Or two doses** of individual rubeola vaccine Dose #1 ____ Dose #2 ____
Provide documentation of titer results Mo Day Yr
____/____/____
Mo Day Yr
____/____/____
Mo Day Yr

*MUMPS

-Has report of positive immune **titer**. Specify date: ____/____/____ **Or one dose** of mumps vaccine Dose #1 ____/____/____
Provide documentation of titer results Mo Day Yr
Mo Day Yr

*RUBELLA (GERMAN MEASLES)

-Has report of positive immune **titer**. Specify date: ____/____/____ **Or one dose** of rubella vaccine Dose #1 ____/____/____
Provide documentation of titer results Mo Day Yr
Mo Day Yr

Tuberculosis Screening : Must be placed and read in the United States for ALL students. The Mantoux type test must have been placed within 6 months of entering Indiana State University for U.S. born students and within 4 weeks on arrival to the United States for international students.

A. Tuberculin Skin Test

Date given: ____/____/____ Date read: ____/____/____ Results: _____ mm
Mo Day Yr
Mo Day Yr
(Record actual mm of induration, transverse diameter; If no induration, write "0")

Interpretation (based on mm of induration as well as risk factors) Positive Negative

B. Chest X-Ray (required if tuberculin skin test is positive or if PPD has not been placed and patient is at risk of disease.)

Result: Normal Abnormal Date of chest x-ray: _____

C. **I have received and read the Meningococcal Meningitis Vaccine information sheet.** I understand that the Meningococcal Meningitis Vaccine offers protection against certain strains of Neisseria Meningitis. This vaccine is available at ISU Student Health Center for a fee. The vaccine may also be available through family physician offices or clinics. If vaccine has been given enter: ____/____/____.
Mo
Day
Yr

Student Signature (If student is 18 years or older) _____ Date _____

Parent/Guardian Signature (If student is less than 18 years) _____ Date _____

HEALTH CARE PROVIDER: (signature required as validation of correct information for immunizations and TB assessment)

Name: _____ Address: _____

Signature: _____ Phone: _____ Date: _____

Please circle one: LPN, RN, PA-C, NP, MD, DO

TURN PAGE OVER

II. RECOMMENDED VACCINATIONS

Based on American College Health Association (ACHA) and the CDC guidelines, the following immunizations are recommended, not required, and offered by the Student Health Center. Consult your personal physician or Student Health Center if you have questions about these immunizations.

HEPATITIS B:

1. Hepatitis B Vaccination..... Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
 Mo Day Yr Mo Day Yr Mo Day Yr

Or

2. Twinrix (HEPATITIS A/B) ... Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
 Mo Day Yr Mo Day Yr Mo Day Yr

HEPATITIS A: Dose #1 ___/___/___ Dose #2 ___/___/___
 Mo Day Yr Mo Day Yr

VARICELLA: (chicken pox): Two doses one month apart recommended for adults with no history of disease:

Dose #1 ___/___/___ Dose #2 ___/___/___
 Mo Day Yr Mo Day Yr

POLIO : Has report of positive immune **titer.** Specify date: ___/___/___ Or Primary Series: Yes No

Last Booster Date: ___/___/___
 Mo Day Yr

MEDICAL CONTRAINDICATION STATEMENT

The individual identified on this form has been diagnosed with a medical condition which precludes receiving the following vaccines:

VACCINE	MEDICAL CONTRAINDICATION*	DURATION OF CONTRAINDICATION

It is understood in the event the disease (except Tetanus) for which this exemption requested occurs on campus, the individual will be excluded from ALL campus activities until Public Health Authorities declare the threat of disease has ended. This action is taken to prevent the spread of disease to the individual who cannot medically receive the vaccine.

NOTE: Name, address telephone number and **SIGNATURE** of the physician are required to validate the medical exemption. **STAMP SIGNATURES ARE NOT ACCEPTED.**

Physician Name _____
 Address _____
 Telephone Number _____
 Signature _____

Medical Contraindication to Vaccine must be in accordance with recommendations of Advisory Committee on Immunization Practices listed below: General Contraindications

- Anaphylactic reaction to a vaccine contraindicates future doses of vaccine.
- Anaphylactic reaction to a vaccine substance contraindicates the use of vaccine containing that substance.

Contraindications to MMR

- Anaphylactic reaction to eggs or Neomycin
- Pregnancy
- Known altered immunodeficiency (hematologic & solid tumors, congenital immunodeficiency or long term immunosuppressive therapy)

Contraindication to TB (Mantoux) skin test

- Recent live virus vaccines (MMR). Apply TB Mantoux (PPD) skin test 4-6 weeks after administration of live virus vaccine.
- Documentation of Positive Mantoux (PPD). (Must be reviewed by Student Health Center Staff)

Distance Education

I may be exempt from the above immunizations as I am **totally enrolled** in distance education. I will **never** be on campus. **PLEASE NOTE:** Please check with the department of your major to see if providing immunization records is a requirement. Some areas within ISU require every enrolled student to provide this documentation.

Name (Print): _____

Signature: _____

Date: _____