

## Immunization Form

Please return this completed form to: Office of Registration and Records, 200 N 7th St., Terre Haute, IN 47809. Fax: 812-237-8039 or email to: [ISU-ORR@mail.indstate.edu](mailto:ISU-ORR@mail.indstate.edu)

This form must be completed in **ENGLISH** and signed by (1) the student (parent or guardian if the student is under age 18.) The form should also be signed by a medical provider. If the form is not signed by a medical provider, you **MUST** submit: (a) a physician's certificate; (b) immunization records forwarded from another school or postsecondary institution; (c) a certificate record maintained by the student or parent of the student showing the month/day/year in which each dose of vaccine was administered; or (d) evidence of having met alternative criteria.

\_\_\_\_\_  
 Last Name                      First Name                      Middle Name                      University ID # (XXX-XX-XXXX)                      Date of Birth (MM/DD/YYYY)

### Section 1: Measles/Mumps/Rubella

If you were born before 1957, you are considered immune to measles, mumps and rubella and are not required to complete this section. ALL students born in or after 1957 must complete either Box A, Box B, or Box C:

Box A: MMR Vaccination

**First measles vaccination must have been after 12 months of age, and the second must be at least 30 days after the first dose.**

MMR Dose #1: \_\_\_\_\_

MMR Dose #2: \_\_\_\_\_

Box B: Separate Immunizations

**First measles vaccination must have been after 12 months of age, and the second must be at least 30 days after the first dose.**

Measles Dose #1: \_\_\_\_\_

Measles Dose #2: \_\_\_\_\_

Mumps Dose #1: \_\_\_\_\_

Rubella Dose #1: \_\_\_\_\_

Box C: Positive Antibody Titers

**Copy of lab report must also be submitted.**

Measles Titer \_\_\_\_\_

Mumps Titer \_\_\_\_\_

Rubella Titer \_\_\_\_\_

### Section 2: Tetanus/Diphtheria Booster

**ALL** students must provide evidence of a tetanus/diphtheria booster given within the last 10 years:

Booster Date: \_\_\_\_\_

### Section 3: Meningitis

**Meningitis Conjugate- 1 dose**

- MCV4/Menactra®/Menveo®
- On or after 16th birthday

Dose #1: \_\_\_\_\_

**AND**

**Meningococcal Group B**

**MenB-4C (Bexsero®)                      OR                      MenB-FHbp (Trumenba®)**

Two doses – at least one month apart

Dose #1: \_\_\_\_\_

Dose #2: \_\_\_\_\_

**Option A:** Two doses – initial dose and six months later

**Option B:** Three-doses – initial dose, two months and six months later

Dose #1: \_\_\_\_\_

Dose #2: \_\_\_\_\_

Dose #3: \_\_\_\_\_

### Section 4: Tuberculosis

**ALL International students** are required to submit Tuberculosis (TB) screening information to Indiana State University. Students that are US Citizens are not required to submit this information. A QuantiFERON® blood test must be performed in the United States to be considered valid for Indiana State University. Testing is to be done within the first two weeks of the start of your first semester attending Indiana State University. Testing is available at the campus health center for a reasonable fee. Tuberculosis (TB) test results should be submitted separately from this form---with clear student identification on the test results---to the Office of Registration and Records.

**For Medical Provider:** I attest the above information is correct and can be supported by medical records on file:

\_\_\_\_\_  
 Medical Provider Signature                      Medical Provider Printed Name                      Date

**I have reviewed the above information and believe it to be accurate.**

\_\_\_\_\_  
 Student Signature                      Date                      Parent/Guardian Signature (if student under age of 18)                      Date