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

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

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

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

* 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? * ........................................ 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 patient 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, Armenia, Azerbaijan, Bangladesh, Belarus, Brazil, Botswana, Bulgaria, Cambodia, Cameroon, Central African Republic, China, Congo, DPR Korea, DR Congo, Estonia, Ethiopia, Georgia, Guinea-Bissau, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Latvia, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Republic of Moldova, Russian Federation, Sierra Leone, South Africa, Tajikistan, Thailand, 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 prior to 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. All TB testing must be the same day or 28 days after any live vaccines.

2C - TB SKIN TEST

Use Mantoux test only

Date Planted: ___/___/____

Interpretation:Neg.  Pos.  mm induration

(If no induration, mark “0”)

Date Read: ___/___/____

-OR- TB BLOOD TEST

Quantiferon:  *

Other: ____________

Date: ___/___/____

□ Normal  □ Abnormal

Result: Neg.  Pos.  *

Enclose copy of lab report

2D - CHEST X-RAY*

Cheest X-Ray Date: ___/___/____

□ Normal  □ Abnormal

*Enclose copy of USA x-ray report

2E - MEDICATION TREATMENT FOR TB:

Drug: ____________

Dose and Frequency: ____________

Treatment: Start Date ___/___/____

End Date ___/___/____

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

- **Menactra® (conjugate)**
  - Dates: #1__/__/__, #2__/__/__
- **Menveo® (conjugate)**
  - Dates: #1__/__/__, #2__/__/__
- **Menomune® (polysaccharide)**
  - Dates: #1__/__/__, #2__/__/__

**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.

#### RECOMMENDED IMMUNIZATIONS

**TETANUS-DIPHTHERIA-PERTUSSIS**

- Completed primary series of tetanus-diphtheria-pertussis immunizations
- Td
- Tdap Booster within the last 10 years

**POLIO (POLIOMYELITIS)**

- Completed primary series of polio immunization
- Dates: #1__/__/__, #2__/__/__

**HEPATITIS A**

- Dates: #1__/__/__, #2__/__/__

**HEPATITIS B**

- Dates: #1__/__/__, #2__/__/__
- #3__/__/__ OR

**HEPATITIS B surface antibody**

- Result: Reactive___Non Reactive___

**COMBINED HEPATITIS A and B VACCINE**

- Dates: #1__/__/__, #2__/__/__, #3__/__/__

**HPV**

- Gardasil® Dates: #1__/__/__, #2__/__/__, #3__/__/__

**VARICELLA (Chicken Pox)**

- #1__/__/__, #2__/__/__, OR Disease Date ___/__/__

**MENINGITIS B VACCINE:**

- Trumenba: #1__/__/__, #2__/__/__, #3__/__/__
- Bexsero: #1__/__/__, #2__/__/__

**OTHER**

- Date __/__/__

A physical examination is **NOT REQUIRED.** • ALL INFORMATION MUST BE IN ENGLISH. • PLEASE PRINT.

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*Immunization Exemptions: A letter is required for religious exemption. A healthcare practitioner’s note is required for medical exemption.*

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**Form# C/IM-01**

**Rev. 3/18**