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. *Refer to Alert Paper

Student Name________________________________________________
Date of Birth ___________________________ UD ID #____________________
Country of Birth__________________________________________________ If not USA, indicate when you entered this country  ____________
Date Planted: ___/____/____ Date Read: ___/____/____

PARENTAL/GUARDIAN PERMIT (FOR STUDENTS UNDER AGE 18) I give my permission for medical care and 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. I give my permission to bill for any medical care performed.
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 and at least 28 days apart.)

MMR Dates #1 ___/____/____, ___/____/____ /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? ................................................................. No Yes
2. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)? .............................. No Yes
3. Were you born in a country listed below? * .............................................. No Yes
4. Have you traveled or lived for more than one month in any country listed below? * .................................................. No Yes
5. Have you ever had changes on a prior chest x-ray suggesting inactive or past TB disease? ............................................. No Yes
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? ........................................ No Yes
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? ...................... No Yes
8. Do you have a history of illicit drug use? ......................................................... No Yes

* Angola, Bangladesh, Brazil, Central African Republic, China, Congo, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, Ukraine, UR Tanzania, 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 this requirement. If your 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. □
Pos. □
Result: Neg. □ Pos. □

2D - CHEST X-RAY* Chest X-Ray Date : ___/____/____
Pos. □
Abnormal □

2E - MEDICATION TREATMENT FOR TB:

Drug: ___________________________

Dose and Frequency: ___________________

Treatment: ___________________________
Start Date ___/____/____ End Date ___/____/____

*Enclose copy of USA x-ray report

See reverse side of form for additional immunization history, religious/medical exemption, and practitioner’s signature.
3. REQUIRED VACCINE - ALL STUDENTS

**MENINGOCOCCAL MENINGITIS VACCINE**

- Menactra® Vaccine Dates #1 _____/_____/_____ #2 _____/_____/_____  
  (conjugate)  
- Menevo® Vaccine Dates #1 _____/_____/_____ #2 _____/_____/_____  
  (conjugate)  
- Menomune® Vaccine Dates #1 _____/_____/_____ #2 _____/_____/_____  
  (polysaccharide)

**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.

University of Delaware students are required to be vaccinated with meningococcal conjugate vaccine. If they received this vaccine before their 16th birthday, they must 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 meningococcal disease 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 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, Menevo®, 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  
  M          D          Y
  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

**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

**MENINGOCITIS B VACCINE**

- Trumenba® Dates #1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____  
  M          D          Y                           M          D          Y                           M          D          Y
- Bexsero® Dates #1 _____/_____/_____ #2 _____/_____/_____  
  M          D          Y                           M          D          Y

**OTHER**

Date   OTHER     Date  
M          D          M          D

**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 ___________________________ Address ___________________________

Signature ___________________________ Date ___________ Phone (________) ___________________________