Student ID #: _____

Student Immunization Form

Indiana State Law requires students to document immunizations in English for the following: Measles, Mumps, Rubella, Meningitis, Tetanus, and Diphtheria. If you intend to enroll at the University, complete and return this form to the University Health Center prior to the start of your first semester. Call (812) 461-5285 if you have any questions.

Name _____
Last First Mi

Permanent Address _____ Phone _____

City_____State_____Zip _____ Date of Birth_____/_____/ _____

Measles, Mumps, and Rubella (MMR): Must have the following:
Two immunizations required at least thirty days apart (after 1957 & not before first birthday)
1st immunization ..... month/day/year received _____/_____/ _____
2nd immunization ..... month/day/year received _____/_____/ _____
Or
Measles titer ..... month/day/year tested _____/_____/ _____ Results _____
Mumps titer ..... month/day/year tested _____/_____/ _____ Results _____
Rubella titer..... month/day/year tested _____/_____/ _____ Results _____
Vaccine not required if born before January 1, 1957_____(Please check only if applicable)

Tetanus/Diphtheria: TD booster within last 10 years required (Tetanus toxoid alone is not acceptable)
Immunization ..... month/day/year received_____ /_____ /_____

Meningitis vaccine: Meningococcal conjugate vaccine (MCV4): Single dose administered at 16 years of age or older

Most Recent Dose:_____ /_____ /_____

Tuberculosis (International Students Only): All International students (those who are not Citizens or Permanent Residents of the United States) must provide documentation of TB testing prior to the start of their first semester of enrollment at USI. This testing must occur no earlier than 6 weeks before the start of the semester. **This test may be done with a TB blood test or a TB skin test administered in the United States by a medical professional.** Send medical documentation including your student ID number to the University Health Center (Contact information found below).

Date given_____/_____/ _____ Date Read_____/_____/_____ Results_____mm induration

Signature of physician or registered nurse reading test _____
Chest x-ray required if reading is 10 mm or greater: Date of chest x-ray_____/_____/_____Results _____

Physician's Signature: Note: If not signed by a physician/registered nurse, you **must** provide documentation of immunizations.

Name (print) _____ Signature _____

Physician's Address and Phone No.

Address: _____

Phone: _____ Fax _____

Please return this form/documentation of immunizations in one of the following ways:

Fax: (812) 465-7170
Email: immunizations@usi.edu

Mail to: Immunization Forms Enclosed
USI Deaconess Clinic
University of Southern Indiana
8600 University Blvd., RFWC, Room 260
Evansville, IN 47712

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* of Vaccine	Probable Duration of Contraindication

It is understood that in the event that a case of measles, mumps, or rubella is discovered on campus, the individual may be temporarily excluded from classes, residence halls, or the USI campus while a public health threat exists. This action may be taken to help prevent the spread of disease to the individual who cannot medically receive the vaccine.

Note: Name, address, phone and signature of physician required to validate medical contraindication:

Name _____

Address _____

Phone _____ Fax _____

Signature _____ Printed Name _____

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

General Contraindications

1. Anaphylactic reaction to a vaccine contraindicates future doses of the vaccine
2. Anaphylactic reaction to a vaccine substance contraindicates the use of vaccines containing that substance

Contraindications to MMR

1. Anaphylactic reaction to eggs or neomycin**
2. Pregnancy
3. Known altered immunodeficiency (hematologic and solid tumors, congenital immunodeficiency, or long term immunosuppressive therapy)
4. Measles vaccine should not be given for at least six weeks (preferably three months) after a person has received IG, whole blood, or other antibody containing products.

Contraindications to Tuberculosis Test

1. Students have recent viral infections or live virus vaccines (i.e. MMR). To obtain an accurate result when infection is strongly suspected, it is best to repeat testing several weeks after the illness, and 4-6 weeks after administration of the vaccine.
2. Past documented history of positive Mantoux or other TB Test. Chest x-ray required.

** Vaccinate only with extreme caution. Consult protocols for vaccinating such person (J Pediatrics 1983; 102:196-9 and J Pediatrics 1988; 113-:504-6)

Revised 8.03.26