



Student Immunization Form

Indiana State Law and Indiana University policy require students to document immunizations in English for the following diseases. Please complete and return this form to the Student Administration Office, OPT room 310 prior to the start of your first semester. Call 812/855-1917 if you have questions.

Last Name _____ First Name _____ Middle _____

University ID Number _____ - _____ - _____ Date of Birth _____
Month / Day / Year

Please your degree program OD OPT VSCI _____ Anticipated year of graduation

Tetanus/Diphtheria: TD booster within the last ten years required (Tetanus alone not acceptable) You must maintain current Tetanus throughout the duration of your degree program.
Immunization _____ Month/day/year received _____ / _____ / _____

Meningitis Vaccination Information

Indiana State Law requires the University to inform you of the risks associated with meningococcal disease and the benefits of vaccination. Information is provided in Orientation packets for new students and information can also be viewed at <http://www.indiana.edu/~health/meningitislist.html> or can be reviewed in the Office of the Registrar, Franklin Hall 100.

All students are required to sign below.

I have read and understand the risks associated with meningococcal disease as well as the benefits of vaccination.

Student Signature Required

Parent Signature Required (if student is under 18 years of age)

Measles, Mumps, Rubella (MMR): MMR vaccine is recommended to provide protection against measles, mumps and rubella.

1st immunization --- immunized at 12 months of age or later AND Month/day/year received _____ / _____ / _____
2nd immunization --- immunized at least 30 days after Dose 1. Month/day/year received _____ / _____ / _____

OR provide the following information and attach documentation.

Measles (Rubeola): (ten day measles):

Physician-diagnosed measles disease

Month/day/year diagnosed _____ / _____ / _____

Or has laboratory evidence of immune titer

Month/day/year tested _____ / _____ / _____ Results _____

Vaccine not required if born prior to January 1, 1957

_____ (Please check if applicable)

Mumps:

Physician-diagnosed mumps disease

Month/day/year diagnosed _____ / _____ / _____

Or mumps titer

Month/day/year tested _____ / _____ / _____ Results _____

Vaccine not required if born prior to January, 1957

_____ (Please check if applicable)

Hepatitis B:

1st immunization Month/day/year received ____ / ____ / ____

2nd immunization Month/day/year received ____ / ____ / ____

3rd immunization Month/day/year received ____ / ____ / ____

Tuberculin Skin Test (mantoux only): Prior to the start (no earlier than 6 months) of the first semester at IUSO and annually while in clinical training. Must be administered and read in the United States by registered nurse or physician within 48-72 hours.

Date given ____ / ____ / ____ Date Read ____ / ____ / ____ Results _____ mm duration

Signature of Physician or registered nurse reading test

Chest x-ray required if reading 10mm or greater:

Date of chest x-ray Month/day/year received ____ / ____ / ____ Results _____

INH treatment if indicated: Started ____ / ____ / ____ Completed ____ / ____ / ____

Note: If not signed by a physician/registered nurse, you must provide proof of all immunizations documented.

Physician/Registered Nurse Name:

Printed Name

Physician/Registered Nurse Signature

Date

Clinic Stamp: