OSU UNIVERSITY HEALTH SERVICES

Official Notice: Immunization Requirements for Oklahoma State University Students

Beginning with the fall semester 2004, Oklahoma state law requires that all new students who attend Oklahoma colleges and universities for the first time provide proof of immunization for certain diseases. If you cannot verify your immunizations you will need to be re-immunized. Medical, religious and personal exemptions are allowed by law and such requests must be made in writing using the OSU Certificate of Exemption form available at www.okstate.edu/UHS/.

Acceptable documentation of immunizations includes any of the following:

Signature of a physician or nurse on this form, page 4, verifying the accuracy of submitted information.
Copies of shot records.
Copies of medical records.
Copies of school health records.
Copies of laboratory test results demonstrating immunity.

Immunizations Required by State Law

Vaccination	Who must comply	Compliance Requirements	Compliance Date
Meningitis*	All new students living in campus housing	Proof of vaccination or signed declination	At move in
Measles, Mumps, Rubella, TWO DOSES	All new students born after January 1, 1957	Proof of vaccination with **2 doses** of vaccine; or lab test demonstrating immunity; or, signed Certificate of Exemption	End of the fourth week of classes
Hepatitis B	All new students	Proof of completion of a Hep B series or signed Certificate of Exemption	Minimum of first 2 shots by 6th week of class; completion of series by 4th week of the student's second semester

***Specific information regarding immunization for meningitis**:
Oklahoma Law requires that first time enrollees who reside in **on-campus student housing** be vaccinated against meningococcal disease **UNLESS**, 1) the individual signs a written waiver that he/she has reviewed the information provided by OSU regarding meningitis immunization and has chosen not to be immunized, or, 2) in the case of a minor, the individual's parent or guardian signs such written waiver.

FAILURE TO COMPLY WITH THESE REQUIREMENTS WILL RESULT IN A HOLD BEING PLACED ON FUTURE ENROLLMENT

All required immunizations are available at University Health Services.

Certain students are also required to comply with OSU requirements for tuberculosis testing. This policy is explained on page 2 of this form.

Please bring this completed form with you to enrollment OR mail to:
OSU Health Services
1202 W. Farm Road
Stillwater, OK 74078-2036
405-744-3252
FAX 405-744-6556

Information Regarding Tuberculosis Testing

All new students at OSU are required to comply with a Tuberculosis testing policy. This policy affects all students based on residency and health status. This policy requires all students who meet any of the criteria below to provide evidence of having been tested for Tuberculosis within the six months prior to coming to OSU, OR by the fourth week of classes.

Who Must Comply

Students currently holding a visa from U.S. Immigration Service

A student who is a U.S. citizen currently or previously residing outside the U.S.

Students with a health/medical condition that suppresses the immune system

Students with known exposure to someone with active tuberculosis disease

If any of these apply to you, you will need to comply with the Tuberculosis testing requirement. For other students, this is a recommendation.

TO COMPLY:

Provide a medical record in English from a physician, clinic or hospital indicating that you have been tested for Tuberculosis **or** provide documentation of a negative chest x-ray within the previous 6 months. These records must include the date of the test(s) and the results of the test(s).

The following procedure for the skin test must be used:

0.1 ml of Purified Protein Derivative, (Mantoux), solution intradermally to the inner forearm.

Results must be read within 48-72 hours of administration. **Documentation must include date given, date read and results in mm.** Please document zero mm if no reaction.

OR

Submit to a TB skin test at University Health Services during the first four weeks of the semester.

OR

Provide a medical record indicating successful treatment for TB disease.

Please note: Having received BCG vaccination does <u>NOT</u> exempt you from the testing requirement.

If you have had a positive skin test, a chest x-ray is required to show the absence of active disease.

Failure to comply may prevent enrollment for your next semester.

(Please Detach Here)

OSU UNIVERSITY HEALTH SERVICES

All new students must complete both sides of this form

Medical History

1202 West Farm Road
Stillwater, OK 74078-2036
405-744-7665

Please indicate the first semester you attended
__ Fall
__ Spring
__ Summer

NAME: _____ Male _____ Female _____
(Last) (First) (Middle)

Social Security # or ID # _____ Date of Birth _____

Citizenship U.S. ____ Other (Specify) _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone: Home ( ) _____
Work ( ) _____

MEDICAL HISTORY—Have you ever had any of the following: (check if applicable)

___ Alcohol Abuse	___ Anemia	___ Arthritis	___ Asthma
___ Back Problems	___ Chronic Cough	___ Cancer	___ Colitis
___ Convulsions/Seizures	___ Depression	___ Diabetes	___ Disability
___ Drug Abuse	___ Eating Disorder	___ Chronic Hayfever	___ Hepatitis
___ Headache Chronic/Migraine	___ Heart Disease	___ Head Injury	___ Hernia
___ High Blood Pressure	___ High Cholesterol	___ Heart Murmur	___ Hemophilia
___ Intestinal/Stomach Disorders	___ Malaria	___ Kidney Disease	___ Mono
___ Menstrual Problems/Pain	___ Orthopedic Problems	___ Pneumonia	___ Polio
___ Psychological Counseling	___ Sickle Cell Disease	___ Rheumatic Fever	___ Mumps
___ Loss of Consciousness/Fainting	___ Sleep Disorder	___ Stroke	___ TB
___ Positive TB Skin Tests	___ Thyroid Disease	___ Spleen Removed	___ Measles
___ Chronic Sinus Infections	___ Chicken Pox	___ Chronic Bladder/Urinary Infections	

Brief Explanation of any POSITIVE Responses: _____
_____

History of Surgery: Yes No Ongoing Medical Problems: Yes No (If Yes, List Below)
_____
_____

Environmental Allergies: _____
_____

Medication Allergies: Yes No
(List Medication/Reaction) _____
_____
_____
_____

List current medications:
_____
_____
_____
_____
_____
_____
Herbs _____

Tobacco Use: Yes No
Type _____ Frequency _____

ALL INFORMATION PROVIDED IS CONFIDENTIAL

Please complete other side

Immunization Record

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER OR ATTACH COPIES OF RECORDS

All information must be in English

REQUIRED (Mandatory) Immunization for University Students: Two Doses of MEASLES, MUMPS AND RUBELLA (MMR) vaccine.

Vaccine	Enter date each immunization was given		
Measles (Month, Day, Year)	#1	#2	• Measles, mumps and rubella (MMR) vaccine is not required for college students born before January 1957. • The first MMR must haven been given no earlier than 4 day before the first birthday. The 2nd dose of measles, mumps and rubella vaccine or of measles vaccine must have been administered at least 28 calender days after the 1st dose. • In lieu of immunization, written evidence of laboratory tests showing range of immunity to measles, mumps, rubella is acceptable. Attach written proof to the Certificate.
Mumps (Month, Day, Year)	#1	#2	
Rubella (Month, Day, Year)	#1	#2	

Hepatitis B (Month, Day, Year)	#1	#2	#3

RECOMMENDED (Other) Immunizations

Hepatitis A (Month, Day, Year)	#1	#2	Polio OPV/IPV	#1	
Tetanus-Diphtheria DTaP or DTP and booster with Td	#1	#2	#3	#4	(Td) booster

Meningococcal Quadrivalent polysaccharide vaccine	#1

Tuberculosis Screening **(See page 2 for detailed information)**

Enter date test was given (Month, Day, Year)

#1
#2

1. PPD (Mantoux) within the past 6 months (tine or monovac not acceptable)

   Result:_____(measured in mm of Induration). Please document 0 mm if no reaction
2. If PPD is positive (10mm or greater), chest X-ray required:
   X-ray result: Normal _____ Abnormal _____
3. If previously treated for TB, please submit copies of medical records indicating treatment & outcome of treatment.

If completed by physician

To the best of my knowledge, the person above has received the above immunizations

Signed _____ Title _____ Date _____

(Physician, nurse or school authority- Do not sign unless minimum requirement for MMR - measles, mumps and rubella - and Hepatitis B - are met)

AUTHORIZATION FOR MEDICAL TREATMENT

For All Students:
By signature, I verify that the information on this form is accurate and true. By signature I give permission for diagnosis, therapeutic, and operative procedures as may be deemed necessary for me.

Signature _____ Printed Name _____ Date _____

For all students under 18 years of age:
I authorize the OSU Health Services to administer medical and surgical services, immunizations and therapeutic procedures as deemed necessary by duly licensed personnel.

Parent's or Guardian's Signature _____ Relationship _____ Date _____