## REQUIRED IMMUNIZATIONS:

1. Tetanus/ Diphtheria- Completed primary series:
   - Month______ Day______ Year______
   - Tdap booster within last 10 years - required:
     - Month______ Day______ Year______

2. Polio- Completed primary series - required:
   - Type of vaccine_____ OPV and / or _____ IPV
     - Month______ Day______ Year______

3. MMR 2 doses after 12 months of age - required:
   - Month______ Day______ Year______ (1st dose)
   - Month______ Day______ Year______ (2nd dose)

4. Hepatitis B Vaccine Series - required:
   - Month______ Day______ Year______ (1st dose)
   - Month______ Day______ Year______ (2nd dose)
   - Month______ Day______ Year______ (3rd dose)

5. Varicella Vaccine Series - required:
   - Month______ Day______ Year______ (1st dose)
   - Month______ Day______ Year______ (2nd dose)
   - If history of illness, titer is required:
     - Reactive _____ Non-reactive _____

6. Meningococcal Vaccine A, C, Y, and W-135 OR Menactra Vaccine - required- within last 5 yrs *:
   - Month______ Day______ Year______
   - * One dose required ON or AFTER 16th birthday

7. Meningococcal Group B Vaccine Series - required
   - Month______ Day______ Year______ (1st dose)
   - Month______ Day______ Year______ (2nd dose)
   - Month______ Day______ Year______ (3rd dose) *
   - *3rd dose, IF NEEDED – Trumenba only

## RECOMMENDED IMMUNIZATIONS:

Hepatitis A Vaccine Series (2 doses) - recommended:
   - Month______ Day______ Year______ (1st dose)
   - Month______ Day______ Year______ (2nd dose)

Influenza Vaccine (most recent) – recommend annually:
   - Month______ Day______ Year______

HPV Vaccine Series (2-3 doses) - recommended:
   - Month______ Day______ Year______ (1st dose)
   - Month______ Day______ Year______ (2nd dose)
   - Month______ Day______ Year______ (3rd dose IF NEEDED)

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Please see other side of this form for Tuberculosis (TB) testing information and required student questionnaire
PPD/Tuberculin Skin Test

Is student a member of a high risk group?  

Date Placed: Month____ Day____ Year______  

Date Read: Month____ Day____ Year______  

Result: _____mm induration  

_____Positive  _____Negative

TUBERCULOSIS (TB) RISK QUESTIONNAIRE  Required - To be completed by ALL students:

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 TB? ............. □ Yes  □ No

3. Were you born in one of the countries listed below? * ............................................. □ Yes  □ No

4. Have you traveled or lived for more than one month in any of the countries 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, leukemia or lymphomas, low body weight, HIV/AIDS, gastrectomy or intestinal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone >15 mg/day for >1 month), other immunosuppressive disorders, or are you an organ transplant recipient? ........................................... □ Yes  □ No

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? ............. □ Yes  □ No

8. Do you have a history of illicit drug use? ................................................................. □ Yes  □ No

* 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

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.

<table>
<thead>
<tr>
<th>TB SKIN TEST - Use Mantoux test only</th>
<th>OR- TB BLOOD TEST</th>
<th>CHEST X-RAY*</th>
<th>MEDICATION TREATMENT FOR TB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Planted:  <strong><strong>/</strong></strong>/____</td>
<td>Quantiferon:  □*</td>
<td>Chest X-Ray Date</td>
<td></td>
</tr>
<tr>
<td>Date Read:  <strong><strong>/</strong></strong>/____</td>
<td>T-Spot:  □*</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date:  <strong><strong>/</strong></strong>/____</td>
<td>□ Normal  □ Abnormal</td>
<td></td>
</tr>
<tr>
<td>_____mm induration (if no induration, mark “0”)</td>
<td>Result: Neg. □ Pos.. □</td>
<td>*Enclose copy of USA X-Ray Report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Enclose copy of lab report</td>
<td>Drug:  ____________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthcare Provider Name</th>
<th>Provider Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Address</td>
<td>Provider Telephone</td>
<td>Provider Fax</td>
</tr>
</tbody>
</table>

Revised 2-3-20