# Immunization Record for International Students

[Patient label goes here]

Patient's Name_____

Student ID#_____

Family name (*please print all information*) First or given name Middle or other names

Gender: ☐ Male ☐ Female Date of birth: _____/___/_____
month day year

_____/_____/_____
Your assigned University Student Identification Number
(*if you have one*)

## Required Measles, Mumps, Rubella (MMR) Immunization

MMR: Proof of immunity to MMR is a requirement for registration for classes. The only exception is for females who know or suspect they are pregnant. These individuals are exempt from this requirement until after the delivery of their child.

This requirement is fulfilled if you meet one of the following criteria:

☐ birth date *before* 1957; or

☐ received two doses of MMR vaccine (provide both dates):

#1 _____/___/_____; (must be after your 1st birthday and **in** 1969 or later);
month day year

#2 _____/___/_____ (must be at least 28 days after #1 – usually given at age 4-6 years or later)
month day year

☐ provide to Student Health Service copies of original lab reports of MMR titres that verify immunity to these diseases.

## Required Tuberculosis Screening

- **Do not have a tuberculosis skin or blood test done prior to coming to Iowa**. **TB screening must be done in the United States.**
- **Do not have a BCG vaccination prior to coming to the University of Iowa.**
- **If you are required to have a chest x-ray, it must be done in the United States within three months of starting at the University of Iowa.**
- **If you have been treated for TB infection or disease, bring a copy of your treatment report written in English.**

**If you have had a positive reaction to a tuberculin skin test (Mantoux 5 TU/PPD), that is, swelling greater than or equal to 10 mm as read within 48-72 hours of being tested, bring documentation validated by the signature and stamp/seal of an authorized immunization official.**.

For positive TST test result individuals only: TST given – date: _____/___/_____; TST read – date: _____/___/_____
month/day/year Reaction in mm: _____

Do you have a history of BCG vaccinations? ☐ no ☐ yes – date of most recent BCG: _____/___/_____
month day year

## Validation

To validate this form, have it signed and dated by your physician or authorized immunization official.

_____ Date: _____/___/_____
Signature and stamp/seal of physician or authorized immunization official month day year

[Patient label goes here]

Patient's Name_____

Student ID#_____

# Recommended (but not required) Immunizations and Tests

**We recommend that you have the following immunizations/screening tests.**

- **Chickenpox** (Varicella). Proof of immunity may be established by having:
  ☐ Had vaccination series - (month, day, year) given: #1 _____/_____/_____; #2 _____/_____/_____; **OR**

  ☐ Had the disease - (month, day, year) _____/_____/_____
- **Tdap** (valid only if within 10 years) - (month, day, year) given _____/_____/_____; **OR**
  ☐ Tetanus (valid only if within 10 years) - (month, day, year) given _____/_____/_____; **AND**

  ☐ Diphtheria (valid only if within 10 years) - (month, day, year) given _____/_____/_____
- **Polio** - date (month, day, year) given:_____/_____/_____
- **Hepatitis B series** (month, day, year) given: #1 _____/_____/_____; #2 _____/_____/_____; #3 _____/_____/____; **OR**
  ☐ Hepatitis B antibody titre. (If so, provide a copy of the original lab report). If non-immune, boosters required according to protocol.
  **OR**
  ☐ Hepatitis A/B Combination (month, day, year) given: #1 _____/_____/_____; #2 _____/_____/_____; #3 _____/_____/____
- **HPV** series (month, day, year) given: #1 _____/_____/_____; #2 _____/_____/_____; #3 _____/_____/____
- **Hepatitis A** series (month, day, year) given: #1 _____/_____/_____; #2 _____/_____/_____
- **Meningococcal immunization -** date (month, day, year) given:_____/_____/_____
- **Sickledex screening test**: Sickle cell anemia is an inherited disease of people with African or Mediterranean ancestry, which can be detected by a "sickledex" screening test. ☐ I have not had this test; ☐ I have had this test, the result was: ☐ negative ☐ positive

# Validation

**To validate this form, have it signed and dated by your physician or authorized immunization official.**

_____ Date: _____/___/_____

Signature and stamp/seal of physician or authorized immunization official — month day year

# *Important Information*

If you are under the age of 18 years, parental consent is required before Student Health Service can administer any needed vaccinations/skin test and/or provide medical care and treatment. Please have your parent/guardian sign and date below if permission is given to the University of Iowa Student Health Service to administer vaccines/skin tests and provide medical care and treatment to you.

_____ _____ _____

Signature — Relationship to student — Date

The University of Iowa Student Health Service requests this information for the purpose of patient care.
Persons outside the Student Health Service are not routinely provided this information without the patient's knowledge and written consent.
Responses to all items are required. If you fail to provide this information, patient care may be impaired.

**Submit this form to:**
Student Health Service
4189 Westlawn
The University of Iowa
Iowa City, IA 52242 **OR**

*Submit this form at the Immunization/Screening Clinic during Orientation Week.*