Since there is currently a coronavirus pandemic, I preferred to stay home instead of going to the hospital to get checked. I attach proof that I am vaccinated, and I can testify that I am healthy since I eat healthy and exercise often.

Immunization Status

To be verified by Physician or Health Care Official. All students must have a documented history of immunizations verified by a physician. We will also accept immunization records from your doctor's office, the Health Department, or school records, but must include specific dates for each dose.

	Date Immunized (month/day/year)	**Date Immunized** (month/day/year)
Tetanus (within 10 years)	29-7-2011	
Polio (last in series of 4)	24-4-2001 / 28-6-2001	28-8-2001 / 1-4-2005
*Rubeola (measles)		
*Rubella (German or 30day measles)		
*MMR (Measles, Mumps, Rubeola)	5-6-2002	

At this time, the American Medical Association recommends 2 MMR doses by the time of adulthood.

Arkansas state law requires that if you were born after January 1, 1957 you must have received both vaccines after your first birthday. If you are unable to do this prior to enrollment, you may receive it during registration at no charge.* ***Persons seeking a religious or medical exemption to the Immunization requirements of Arkansas institutions of higher education may obtain an application form from the Student Health Services Offices. Any exemption status must be completed before classes begin.*

AREA DE SALUD SAN RAFAEL HEREDIA * VACUNACION * C.C.S.S.

Laura Mercedes Navarro Mena
Health Care Professional
(Signature of doctor, nurse, nurse practitioner, P.A., or D.O. is REQUIRED)

Consent for Treatment: Consent is hereby given for treatment in University of the Ozarks Student Health Services Office by duly licensed medical personnel or by a health care provider of choice in the community for routine health care, assessment, diagnosis, treatment, and if necessary, hospitalization. No guarantee has been made to me as to the results to be obtained by treatment given to me.

It is understood that the University will contact the next of kin as soon as possible in case of an emergency or serious illness.

Signed: Jose Andre Martinez M. Date: 10/10/2018

Parent or Guardian: Jessica Hernández Campos Date: 10/10/2018
(if student is under 18 years of age)

REGISTRO DE VACUNAS

Mantenga al día las vacunas, así evitará que sus hijos(as) se enfermen.

Para ser llenado por el personal de salud.

TIPO DE VACUNA Y EDAD EN QUE DEBE APLICARSE	ENFERMEDAD QUE PREVIENE	FECHA DOSIS BASICA			FECHA REFUERZOS		
		I	II	III	I	II	III
Tuberculosa BGG Recién nacido(a)	Meningitis Tuberculosa	28-2-01					
Hepatitis B Al nacer, 2 meses y 6 meses	Hepatitis B	28-2-01	27/04/2001	27/8/01			
Haemophilus influenze A los 2 meses, 4 meses y 6 meses	Meningitis por Haemophilus Influenzae tipo B	27/04/2001	28 6.01	27/8/01			
Polio Oral A los 2,4, 6 meses y al año y 3 meses	Poliomielitis	27/04/2001	0 1	27/8/01	ABR 2005		
Diftero, Pertusis Tetánica (DPT) A los 2, 4, 6 meses, al año y 3 meses y a los 4 años	Difteria Tosferina Tétano	27/04/2001	28	27/8/01	05 JUN 2002	ABR 2005	
Saparampión-Rubeola-Parotiditis (SRP) al año y 3 meses. Al ingreso de la escuela	Sarampión Rubeola Paperas	05	JUN	2002	Tdrato		
Diftero Tetánica (DT) En mayores de 6 años que no recibieron DPT. A todo niño o niña a los 10 años.	Difteria Tétanos	29-07 11					
Otros (especifique)	Amarilla	8/8/01					

REGISTRO DE LA PRUEBA METABOLICA O DEL TALON

Esta prueba consiste en extraer una gota de sangre del talón del niño o niña entre el cuarto y sétimo día de nacido, para detectar enfermedades que le pueden producir retardo mental. Si esto no es posible, debe llevarlo (a) antes de los 30 días.

Anote en la casilla correspondiente la fecha en que se toma la muestra.

PRUEBA QUE DEBE REALIZARSE	ENFERMEDADES QUE DETECTA	FECHA MUESTRA INICIAL	FECHA SEGUNDA MUESTRA SOLO SI ES NECESARIO
PKU-MSUD-HC	Hipotiroidismo Congénito Fenilcetonuria Orina de Jarabe de Arce	7/3/01.	