



**SUBMIT THIS FORM TO:**

**Kent State University Health Services**

**1500 Eastway Drive, Kent OH 44242-0001**

**Phone (330) 672-8263 Fax (330) 672-2272 or Email: immunizations@kent.edu**

**Mandatory Student Immunization Requirements**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ KSU ID# \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Birth Country \_\_\_\_\_ E-Mail \_\_\_\_\_

**Students born before Jan. 1<sup>st</sup>, 1957 are exempt from Part I. *All other students must complete and submit Part I***  
**International students must also complete Part II.**

**PART I - MEASLES/MUMPS/RUBELLA (MMR VACCINE)**

Requirement: TWO doses of MMR vaccine after the age of **one** and separated by at least one month Date: #1 \_\_\_\_\_  
#2 \_\_\_\_\_

**-OR-**

If immunizations were NOT given in the MMR combined vaccine – please indicate dates received:

Date: MEASLES #1 \_\_\_\_\_ MUMPS #1 \_\_\_\_\_ RUBELLA #1 \_\_\_\_\_  
MEASLES #2 \_\_\_\_\_ MUMPS #2 \_\_\_\_\_ RUBELLA #2 \_\_\_\_\_

ALL IMMUNIZATION DATES **MUST** BE VERIFIED BY A PHYSICIAN OR HEALTH CARE PROVIDER

**-OR-**

A **COPY** OF YOUR IMMUNIZATION RECORD MUST BE ATTACHED TO THIS COMPLETED FORM

**Healthcare provider's name and address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Healthcare Provider Signature

**PART II – TB SCREENING – *INTERNATIONAL STUDENTS ONLY***

Students from the following countries are required to have tuberculosis screening: Africa, Eastern Europe, Russia, Mexico, Central America, South America, Asia, the Middle East, the Pacific Islands and the Caribbean. This test must be completed within 12 months prior to starting classes.

(For a complete list of the World Health Organizations high risk countries visit World Health Organization Global Health Observatory)

I was **not** born in or had an extended stay in any country listed above

**Tuberculosis Skin Test (Mantoux):** Date Given: \_\_\_\_\_ Date Read : \_\_\_\_\_ Results Required (millimeters) \_\_\_\_\_

If you previously received a **BCG** vaccine, a blood test such as **Quantiferon Gold** is the preferred test to indicate absence of TB.

Date: \_\_\_\_\_ Result (Check one)  Positive  Negative

If a current or past TB screening or Quantiferon Gold Test was positive, you will need to complete the following:

Chest X-ray date: \_\_\_\_\_ Result(Check one)  Positive  Negative

Treatment:  YES  NO – Document drug/dose/frequency \_\_\_\_\_ Date and length of treatment \_\_\_\_\_

Document reason prophylaxis or treatment not done \_\_\_\_\_

**Healthcare Provider's Name and Address:** \_\_\_\_\_

**Healthcare Provider's Signature:** \_\_\_\_\_