Indiana State University
More. From day one.

Office of Registration & Records
Phone: (812) 237-2020 **Fax: (812) 237-8039**

Immunization Form

Please return this completed form to: Office of Registration and Records, 200 N 7th St., Terre Haute, IN 47809. Fax: 812-237-8039 or email to: ISU-ORR@mail.indstate.edu

This form must be completed in **ENGLISH** and signed by (1) the student (parent or guardian if the student is under age 18.) The form should also be signed by a medical provider. If the form is not signed by a medical provider, you MUST submit: (a) a physician's certificate; (b) immunization records forwarded from another school or postsecondary institution; (c) a certificate record maintained by the student or parent of the student showing the month/day/year in which each dose of vaccine was administered; or (d) evidence of having met alternative criteria.

Last Name _____ First Name _____ Middle Name _____ ID# (991-XXX-XXX) _____ Date of Birth (MM/DD/YYYY) _____

Section 1: Measles/Mumps/Rubella

If you were born before 1957, you are considered immune to measles, mumps and rubella and are not required to complete this section. ALL students born in or after 1957 must complete either Box A, Box B, or Box C:

Box A: MMR Vaccination

First measles vaccination must have been after 12 months of age, and the second must be at least 30 days after the first dose.

MMR Dose #1: _____

MMR Dose #2: _____

Box B: Separate Immunizations

First measles vaccination must have been after 12 months of age, and the second must be at least 30 days after the first dose.

Measles Dose #1: _____

Measles Dose #2: _____

Mumps Dose #1: _____

Rubella Dose #1: _____

Box C: Positive Antibody Titers

Copy of lab report must also be submitted.

Measles Titer: _____

Mumps Titer: _____

Rubella Titer: _____

Section 2: Tetanus/Diptheria Booster

ALL students must provide evidence of a tetanus/diptheria booster given within the last 10 years:

Booster Date: _____

Section 3: Meningitis Education

Meningitis is an inflamation of the lining surrounding the brain and spinal cord. For most college students, the risk of meningococcal disease is similar to that of persons the same age in the general population. For college freshmen who live in residence halls, there is a modestly increased risk of meningococcal disease relative to other persons their age. Lifestyle behaviors that put individuals at increased risk include cigarette smoking, alcohol ingestion, bar patronage, and close, crowded living conditions. Meningococcal vaccine is reasonably safe and effective against the serogroups included in the vaccine. Approximately 70% of meningococcal disease is caused by serogroups covered by the vaccine. Protective levels of antibody usually are achieved 7-10 days after vaccination. The UAP Student Health Center stocks and administers the vaccine. Additional information may be obtained by calling the UAP Clinic at (812) 237-3883 or by visiting:

http://www.indstate.edu/registrar/MenEd.pdf

Submission of this form acknowledges that I have read the complete Meningococcal Meningitis Vaccine information listed above.

Section 4: Tuberculosis

ALL International students are required to submit Tuberculosis (TB) screening information to Indiana State University. Students that are US Citizens are not required to submit this information. Tuberculosis (TB) screening tests must be performed in the United States to be considered valid for Indiana State University. Testing is to be done within the first two weeks of the start of your first semester attending Indiana State University. Testing is available at the campus health center for a reasonable fee. Tuburculosis (TB) test results should be submitted separately---with clear student identification on the records---to the Office of Registration and Records.

For Medical Provider: I attest the above information is correct and can be supported by medical records on file:

Medical Provider Signature _____ Medical Provider Printed Name _____ Date _____

I have reviewed the above information and believe it to be accurate. By signing below, I acknowledge that I have reviewed the information regarding meningococcal meningitis.

Student Signature _____ Date _____ Parent/Guardian Signature (if student under age of 18) _____ Date _____

PLEASE KEEP A COPY FOR YOUR RECORDS