Certificate of Immunization

QUESTIONS?
440-775-8180 or
student.health@oberlin.edu
(e-mail preferred)

RETURN TO:
Oberlin College
Student Health Services 140 West College Street
Oberlin, OH 44074
OR fax to: 440-775-6404 OR e-mail: student.health@oberlin.edu
OR upload to Student Medical Portal

▸ Required of all students *(Page 1 of 5)*

Immunization Requirements can be found at
http://new.oberlin.edu/office/student-health-services/forms.dot

Deadline June 15

The information you provide on this form is strictly for the use of Student Health Services and the Sports Medicine Department and will not be released to anyone without your knowledge and consent. **All full-time students and others utilizing the services of Student Health Services must complete this form. All vaccines should be completed PRIOR to the start of the semester. Enrollment will be delayed until all required sections of this form are completed.**

The only circumstances under which a student may be exempt from the required immunizations listed on this form are as follows:

- Certification in writing by an examining physician who is of the opinion that the physical condition is such that health would be endangered by one or more of the immunizations. The student will be required to submit laboratory evidence of immunity to measles, mumps, and rubella, and if not immune, will have to leave campus in the event of an outbreak.

or

- The student states in writing that the required immunizations would conflict with his or her religious beliefs. The student will be required to submit laboratory evidence of immunity to measles, mumps, and rubella, and if not immune, will have to leave campus in the event of an outbreak.

Name: _____ Date of Birth: _____

Last First Middle Month/Date/Year

REQUIRED IMMUNIZATIONS

A. MMR (Measles, Mumps, Rubella). Two live immunizations required on or after the first birthday, at least 30 days apart.

1. Dose 1 ___/___/___ (mo. day yr.) 2. Dose 2 ___/___/___ (mo. day yr.)

A positive serological test for immunity to any of the above diseases is acceptable instead of immunizations.
A history of disease is not acceptable.

Positive MEASLES titer: ___/___/___ (mo. day yr.) Positive MUMPS titer: ___/___/___ (mo. day yr.) Positive RUBELLA titer: ___/___/___ (mo. day yr.)

B. Tetanus-Diphtheria

1. Primary series DTaP or DTP: ___/___/___ (mo. day yr.) 2. ___/___/___ (mo. day yr.) 3. ___/___/___ (mo. day yr.) 4. ___/___/___ (mo. day yr.)
2. Td booster (within last 10 years): ___/___/___ (mo. day yr.) or Tdap: ___/___/___ (mo. day yr.)

C. Polio

1. Primary series (minimum three dates required for adults >18, four doses are required for <18 years):

☐ OPV (oral) ☐ IPV (injected): 1. ___/___/__ (mo. day yr.) 2. ___/___/___ (mo. day yr.) 3. ___/___/___ (mo. day yr.) 4. ___/___/___ (mo. day yr.)

Name: _____

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STRONGLY RECOMMENDED IMMUNIZATIONS

A. Hepatitis B immunization series

Dose 1. ___/___/___ (mo. day yr.) Dose 2. ___/___/___ (mo. day yr.) Dose 3. ___/___/___ (mo. day yr.)

B. Meningococcal vaccine (Men. ACWY) Dose 1. ___/___/___ (mo. day yr.) Dose 2. (Age≥16, <22) ___/___/___ (mo. day yr.)

C. History of Chickenpox OR chickenpox vaccine

1. Chickenpox: ___/___/___ (mo. day yr.)

OR

2. Chickenpox vaccination: Dose 1.___/___/___ (mo. day yr.)

Dose 2.___/___/___ (mo. day yr.)

D. Human Papilloma Virus (HPV)

Dose 1. ___/___/___ (mo. day yr.) Dose 2. ___/___/___ (mo. day yr.) Dose 3. ___/___/___ (mo. day yr.)

E. Hepatitis A

Dose 1. ___/___/___ (mo. day yr.) Dose 2. ___/___/___ (mo. day yr.)

OTHER IMMUNIZATIONS

A. _____ Dose 1. ___/___/___ (mo. day yr.) Dose 2. ___/___/___ (mo. day yr.) Dose 3. ___/___/___ (mo. day yr.)

B. _____ Dose 1. ___/___/___ (mo. day yr.) Dose 2. ___/___/___ (mo. day yr.) Dose 3. ___/___/___ (mo. day yr.)

C. _____ Dose 1. ___/___/___ (mo. day yr.) Dose 2. ___/___/___ (mo. day yr.) Dose 3. ___/___/___ (mo. day yr.)

_____ _____

Medical Provider Signature Date

Name : _____

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Part I: Tuberculosis(TB) Screening Questionnaire (to be completed by incoming student and verified by provider)

Please answer the following six questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

2. Were you born in, or have you lived in, one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country below) ☐ Yes ☐ No

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

3. Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries above) ☐ Yes ☐ No

4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☐ No

5. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

6. Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? ☐ Yes ☐ No

If the answer is YES to any of the above questions, proceed to page 4. Oberlin College requires that you receive TB testing as soon as possible but at least prior to start of the upcoming semester.

If the answer to all of the above questions is NO, please have your physician sign off on page 5.
No further testing is required.

* *The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Name: _____

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Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. No further testing is required for persons answering NO to all questions and who are low risk for TB. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes** ☐ **No** ☐

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes** ☐ **No** ☐

1. TB Symptom Check[1]

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes ☐ **No** ☐

If No, proceed to 2 or 3

If yes, check below:

- ☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ☐ Coughing up blood (hemoptysis)
- ☐ Chest pain
- ☐ Loss of appetite
- ☐ Unexplained weight loss
- ☐ Night sweats
- ☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ___/___/___ (M D Y) Date Read: ___/___/___ (M D Y)

Result: _____ mm of induration **Interpretation: positive___ negative___

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

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3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ___/___/___ (specify method) QFT-GIT T-Spot ÏÔÈÅÒ____
M D Y
Result: negative positive indeterminate borderline (T-Spot only)

Date Obtained: ___/___/___ (specify method) QFT-GIT T-Spot othÅr____
M D Y
Result: negative positive indeterminate borderline (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ___/___/___ Result: normal___ abnormal____
M D Y

Part III. Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. Patients with a history of BCG vaccination and a positive TST may be cleared with an IGRA. No further testing is necessary if the IGRA is normal and there are no signs or symptoms of TB. Please check one of the management plans below.

_____Student has a positive TST and history of BCG vaccination. Their follow-up IGRA is normal and there are no signs or symptoms of TB.

_____ Student agrees to receive treatment. Please fax or email records of treatment to Oberlin College Student Health Services.

_____ Student has a positive TST, no signs or symptoms of TB, and a normal chest x-ray. The student agrees to be evaluated at the Mercy TB clinic (440-322-8188) when they arrive on campus for possible treatment. The Oberlin College Dean's office will be notified and the student may be restricted from housing and classes if the student fails to follow-up at the TB clinic or refuses to follow their recommendations.

_____ _____

Health Care Professional Signature **Date**