

Certificate of Immunization

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

RETURN TO:
Oberlin College
Student Health Services
247 W. Lorain St., Suite A
Oberlin, OH 44074
OR fax to: 440-775-6404
OR e-mail: student.health@oberlin.edu
(email preferred)

► 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 ___/___/___ 2. Dose 2 ___/___/___
mo. day yr. 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: ___/___/___ Positive MUMPS titer: ___/___/___ Positive RUBELLA titer: ___/___/___
mo. day yr. mo. day yr. mo. day yr.

B. Tetanus-Diphtheria

1. Primary series DTaP or DTP: ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
mo. day yr. mo. day yr. mo. day yr. mo. day yr.

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

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STRONGLY RECOMMENDED IMMUNIZATIONS

A. Hepatitis B immunization series

Dose 1. ____/____/____ Dose 2. ____/____/____ Dose 3. ____/____/____
mo. day yr. mo. day yr. mo. day yr.

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

C. History of Chickenpox OR chickenpox vaccine

1. Chickenpox: ____/____/____ **OR** 2. Chickenpox vaccination: Dose 1. ____/____/____
mo. day yr. mo. day yr.

Dose 2. ____/____/____
mo. day yr.

D. Human Papilloma Virus (HPV)

Dose 1. ____/____/____ Dose 2. ____/____/____ Dose 3. ____/____/____
mo. day yr. mo. day yr. mo. day yr.

E. Hepatitis A

Dose 1. ____/____/____ Dose 2. ____/____/____
mo. day yr. mo. day yr.

OTHER IMMUNIZATIONS

A. _____ Dose 1. ____/____/____ Dose 2. ____/____/____ Dose 3. ____/____/____
mo. day yr. mo. day yr. mo. day yr.

B. _____ Dose 1. ____/____/____ Dose 2. ____/____/____ Dose 3. ____/____/____
mo. day yr. mo. day yr. mo. day yr.

C. _____ Dose 1. ____/____/____ Dose 2. ____/____/____ Dose 3. ____/____/____
mo. day yr. mo. day yr. mo. day yr.

Medical Provider Signature

Date

Certificate of Immunization: (page 3 of 5)**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	Côte d'Ivoire	Japan	Nicaragua	Sudan
Algeria	Croatia	Kazakhstan	Niger	Suriname
Angola	Democratic People's Republic of Korea	Kenya	Nigeria	Swaziland
Argentina	Korea	Kiribati	Pakistan	Syrian Arab Republic
Armenia	Democratic Republic of the Congo	Kuwait	Palau	Tajikistan
Azerbaijan	Djibouti	Kyrgyzstan	Panama	Thailand
Bahrain	Dominican Republic	Lao People's Democratic Republic	Papua New Guinea	The former Yugoslav Republic of Macedonia
Bangladesh	Ecuador	Latvia	Paraguay	Timor-Leste
Belarus	El Salvador	Lesotho	Peru	Togo
Belize	Equatorial Guinea	Liberia	Philippines	Tunisia
Benin	Eritrea	Libyan Arab Jamahiriya	Poland	Turkey
Bhutan	Estonia	Lithuania	Portugal	Turkmenistan
Bolivia (Plurinational State of)	Ethiopia	Madagascar	Qatar	Tuvalu
Bosnia and Herzegovina	Fiji	Malawi	Republic of Korea	Uganda
Botswana	Gabon	Malaysia	Republic of Moldova	Ukraine
Brazil	Gambia	Maldives	Romania	United Republic of Tanzania
Brunei Darussalam	Georgia	Mali	Russian Federation	Uruguay
Bulgaria	Ghana	Marshall Islands	Rwanda	Uzbekistan
Burkina Faso	Guam	Mauritania	Saint Vincent and the Grenadines	Vanuatu
Burundi	Guatemala	Mauritius	Sao Tome and Principe	Venezuela (Bolivarian Republic of)
Cambodia	Guinea	Micronesia (Federated States of)	Senegal	Viet Nam
Cameroon	Guinea-Bissau	Mongolia	Seychelles	Yemen
Cape Verde	Guyana	Morocco	Sierra Leone	Zambia
Central African Republic	Haiti	Mozambique	Singapore	Zimbabwe
Chad	Honduras	Myanmar	Solomon Islands	
China	India	Namibia	Somalia	
Colombia	Indonesia	Nepal	South Africa	
Comoros	Iraq		Sri Lanka	
Congo				

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.

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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 Check¹

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: ____/____/____ Date Read: ____/____/____
 M D Y 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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M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ___/___/___ (specify method) QFT-GIT T-Spot other___
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