



### Student Immunization Form

Indiana State Law and University of Southern Indiana policy require students to document immunizations in English for the following diseases. If you intend to enroll at the University, please complete and return this form to USI Immunization Office prior to the start of your first semester. Call 812-461-5285 if you have questions.

Name \_\_\_\_\_ University ID No. \_\_\_\_\_  
Last First Middle  
Permanent Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ Country \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month Day Year

**Note: MMR vaccine is recommended to provide protection against measles, mumps and rubella (\$55 each at US)**

**\*\*Rubeola:** (ten day measles): Must have the following:  
Two immunizations required **at least thirty days apart** (after 1967 & not before first birthday)  
1st immunization .....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_  
2nd immunization.....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_  
Or measles titer.....month/day/year tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_  
Or physician-diagnosed measles disease.....month/day/year diagnosed \_\_\_\_/\_\_\_\_/\_\_\_\_  
Vaccine not required if born before January 1, 1957 \_\_\_\_\_ (Please check only if applicable)

**\*\*Mumps:** Must have one of the following:  
One immunization (not before first birthday).....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_  
Or mumps titer..... month/day/year tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_  
Or physician-diagnosed mumps disease.....month/day/year diagnosed \_\_\_\_/\_\_\_\_/\_\_\_\_  
Vaccine not required if born before January 1, 1957 \_\_\_\_\_ (Please check only if applicable)

**\*\*Rubella:** (German/three day measles): Must have one of the following:  
One immunization (not before first birthday).....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_  
Or rubella titer .....month/day/year tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_  
Physician-diagnosis rubella disease not acceptable.  
Vaccine not required if born before January 1, 1957 \_\_\_\_\_ (Please check only if applicable)

**\*\*Tetanus/Diphtheria:** TD booster within last 10 years required (Tetanus alone not acceptable) (\$25 at USI)  
Immunization.....month/day/year \_\_\_\_/\_\_\_\_/\_\_\_\_

**Tuberculin Skin Test (TB)**(Mantoux only): **Must be Administered at USI for International Students (\$15)**

Date given \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_ mm duration  
physician within 48-72 hours.  
Signature of physician or registered nurse reading test \_\_\_\_\_

Chest x-ray required if reading 10mm or greater: Date of chest x-ray \_\_\_\_\_ Results \_\_\_\_\_

**\*\*Physician's Signature:** Note: If not signed by a physician/registered nurse, you **must** provide proof of documentation

Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**Over - Medical Contraindication Statement**

# Medical Contraindication Statement

The individual identified on this form has been diagnosed with a medical condition which precludes receiving the following vaccines:

Vaccine	Medical Contraindication* of Vaccine	Probable Duration of Contraindication

It is understood that in the event the disease (except tetanus) for which this exemption requested occurs on campus, the individual will be excluded from all campus activities until Public Health Authorities declare the threat of disease has ended. This action will be taken to prevent the spread of disease to the individual who cannot medically receive the vaccine.

**Note:** Name, address, phone and signature of physician or clinic required to validate medical contraindication:

Name

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Address

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Phone

FAX

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Signature

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**\* Medical Contraindication to Vaccine must be in accordance with recommendations of Advisory Committee on Immunization Practices listed below:**

### General Contraindications

1. Anaphylactic reaction to a vaccine contraindicates future doses of the vaccine
2. Anaphylactic reaction to a vaccine substance contraindicates the use of vaccines containing that substance

### Contraindications to MMR

1. Anaphylactic reaction to eggs or neomycin\*
2. Pregnancy
3. Known altered immunodeficiency (hematologic and solid tumors, congenital immunodeficiency, or long term immunosuppressive therapy)
4. Measles vaccine should not be given for at least six weeks (preferably three months) after a person has received IG, whole blood, or other antibody containing products

### Contraindications to TB (Mantoux) skin test

1. Students having recent viral infections or live virus vaccines (i.e. MMR). To obtain an accurate result when infection is strongly suspected, it is best to repeat testing several weeks after the illness, and 4-6 weeks after administration of the vaccine.
2. Past documented history of positive Mantoux. Chest x-ray required.

\* Vaccinate only with extreme caution. Consult protocols for vaccinating such persons (J Pediatrics 1983; 102:196-9 and J Pediatrics 1988; 113:504-6)



## MENINGOCOCCAL AND HEPATITIS B RISK ACKNOWLEDGEMENT

All students entering the University of Southern Indiana for the first time must meet the immunization requirements of the University and Indiana Code 20-12-71 enacted by the 2002 Indiana General Assembly. Under these requirements, a postsecondary institution in which an individual intends to enroll shall provide detailed information on the risks associated with Meningococcal and Hepatitis B diseases and the availability and effectiveness of vaccines.

*I acknowledge* that I have read the information provided concerning the risks associated with two communicable, life-threatening diseases, Meningococcal and Hepatitis B. Although these immunizations are not mandatory, I recognize that they are strongly recommended.

Signature: \_\_\_\_\_ USI ID# \_\_\_\_\_  
Student at least eighteen (18) years of age

Or

Signature: \_\_\_\_\_  
Parent or guardian, if student is less than eighteen (18) years of age

**\*\*Please complete this acknowledgement and submit with the enclosed Student Immunization Form to complete your immunization record.\*\***

**THIS FORM MUST BE RETURNED**