Official Notice: Immunization Requirements for Oklahoma State University Students

Beginning with the fall semester 2004, Oklahoma state law requires that all new students who attend Oklahoma colleges and universities for the first time provide proof of immunization for certain diseases. If you cannot verify your immunizations you will need to be re-immunized. Medical, religious and personal exemptions are allowed by law and such requests must be made in writing using the OSU Certificate of Exemption form available at www.okstate.edu/UHS/.

Acceptable documentation of immunizations includes any of the following:
Signature of a physician or nurse on this form, page 4, verifying the accuracy of submitted information.
Copies of shot records.
Copies of medical records.
Copies of school health records.
Copies of laboratory test results demonstrating immunity.

Immunizations Required by State Law

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Who must comply</th>
<th>Compliance Requirements</th>
<th>Compliance Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningitis*</td>
<td>All new students living in campus housing</td>
<td>Proof of vaccination or signed declination</td>
<td>At move in</td>
</tr>
<tr>
<td>Measles, Mumps,</td>
<td>All new students born after January 1, 1957</td>
<td>Proof of vaccination with 2 doses of vaccine; or lab test demonstrating immunity; or, signed Certificate of Exemption</td>
<td>End of the fourth week of classes</td>
</tr>
<tr>
<td>Rubella, TWO DOSES</td>
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</tr>
<tr>
<td>Hepatitis B</td>
<td>All new students</td>
<td>Proof of completion of a Hep B series or signed Certificate of Exemption</td>
<td>Minimum of first 2 shots by 6th week of class; completion of series by 4th week of the student’s second semester</td>
</tr>
</tbody>
</table>

*Specific information regarding immunization for meningitis:
Oklahoma Law requires that first time enrollees who reside in on-campus student housing be vaccinated against meningococcal disease UNLESS, 1) the individual signs a written waiver that he/she has reviewed the information provided by OSU regarding meningitis immunization and has chosen not to be immunized, or, 2) in the case of a minor, the individual’s parent or guardian signs such written waiver.

FAILURE TO COMPLY WITH THESE REQUIREMENTS WILL RESULT IN A HOLD BEING PLACED ON FUTURE ENROLLMENT

All required immunizations are available at University Health Services.

Certain students are also required to comply with OSU requirements for tuberculosis testing. This policy is explained on page 2 of this form.

Please bring this completed form with you to enrollment OR mail to:
OSU Health Services
1202 W. Farm Road
Stillwater, OK 74078-2036
405-744-3252
FAX 405-744-6556
Information Regarding Tuberculosis Testing

All new students at OSU are required to comply with a Tuberculosis testing policy. This policy affects all students based on residency and health status. This policy requires all students who meet any of the criteria below to provide evidence of having been tested for Tuberculosis within the six months prior to coming to OSU, OR by the fourth week of classes.

Who Must Comply

Students currently holding a visa from U.S. Immigration Service

A student who is a U.S. citizen currently or previously residing outside the U.S.

Students with a health/medical condition that suppresses the immune system

Students with known exposure to someone with active tuberculosis disease

If any of these apply to you, you will need to comply with the Tuberculosis testing requirement. For other students, this is a recommendation.

TO COMPLY:

Provide a medical record in English from a physician, clinic or hospital indicating that you have been tested for Tuberculosis OR provide documentation of a negative chest x-ray within the previous 6 months. These records must include the date of the test(s) and the results of the test(s).

The following procedure for the skin test must be used:

0.1 ml of Purified Protein Derivative, (Mantoux), solution intradermally to the inner forearm.

Results must be read within 48-72 hours of administration. Documentation must include date given, date read and results in mm. Please document zero mm if no reaction.

OR

Submit to a TB skin test at University Health Services during the first four weeks of the semester.

OR

Provide a medical record indicating successful treatment for TB disease.

Please note: Having received BCG vaccination does NOT exempt you from the testing requirement.

If you have had a positive skin test, a chest x-ray is required to show the absence of active disease.

Failure to comply may prevent enrollment for your next semester.
All new students must complete both sides of this form

Medical History

1202 West Farm Road
Stillwater, OK 74078-2036
405-744-7665

NAME: ________________________________________________________  Male _______  Female ________
   (Last)                                   (First)                                    (Middle)

Social Security # or ID # ____________________________________________  Date of Birth _________________

Citizenship  U.S. ____ Other (Specify) ____________________________________________________________

EMERGENCY CONTACT INFORMATION

Name ______________________________ Relationship _______________  Phone:  Home (     ) _____________
   Work  (     ) ____________

MEDICAL HISTORY—Have you ever had any of the following:  (check if applicable)

___ Alcohol Abuse       ___ Anemia             ___ Arthritis      ___ Asthma
___ Back Problems       ___ Chronic Cough             ___ Cancer      ___ Colitis
___ Convulsions/Seizures       ___ Depression             ___ Diabetes      ___ Disability
___ Drug Abuse       ___ Eating Disorder             ___ Chronic Hayfever      ___ Hepatitis
___ Headache Chronic/Migraine       ___ Heart Disease             ___ Head Injury      ___ Hernia
___ High Blood Pressure       ___ High Cholesterol             ___ Heart Murmur      ___ Hemophilia
___ Intestinal/Stomach Disorders       ___ Malaria             ___ Kidney Disease      ___ Mono
___ Menstrual Problems/Pain       ___ Orthopedic Problems      ___ Pneumonia       ___ Polio
___ Psychological Counseling       ___ Sickle Cell Disease         ___ Rheumatic Fever      ___ Mumps
___ Loss of Consciousness/Fainting       ___ Sleep Disorder             ___ Stroke      ___ TB
___ Positive TB Skin Tests       ___ Thyroid Disease             ___ Spleen Removed      ___ Measles
___ Chronic Sinus Infections       ___ Chicken Pox             ___ Chronic Bladder/Urininary Infections

Brief Explanation of any POSITIVE Responses: _____________________________________________________
   ____________________________________________________________________________________

History of Surgery:    Y es    No       Ongoing Medical Problems:    Y es    No   ( If Yes, List Below )
   ____________________________________________________________________________________
   ____________________________________________________________________________________

Environmental Allergies: _________________________  List current medications:
   ______________________________________________            _______________________________________
   ______________________________________________            _______________________________________
   ______________________________________________            _______________________________________
   ______________________________________________            Herbs  _________________________________

Medication Allergies:     Y es    No              _______________________________________
   (List Medication/Reaction)  _____________________________         _______________________________________
   _________________________________________________         _______________________________________
   _________________________________________________         _______________________________________

Tobacco Use:     Yes    No              Type _________________________________ Frequency _______________________________

ALL INFORMATION PROVIDED IS CONFIDENTIAL

Please complete other side
Immunization Record

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER  OR  ATTACH COPIES OF RECORDS

All information must be in English

REQUIRED (Mandatory) Immunization for University Students:
Two Doses of MEASLES, MUMPS AND RUBELLA (MMR) vaccine.

Vaccine Enter date each immunization was given

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1</th>
<th>#2</th>
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</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Month, Day, Year)</td>
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<td></td>
</tr>
<tr>
<td>• Measles, mumps and rubella (MMR) vaccine is not required for college students born before January 1957.</td>
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</tbody>
</table>
| • The first MMR must have been given no earlier than 4 day before the first birthday. The 2nd dose of measles, mumps and rubella vaccine or of measles vaccine must have been adminis-
| tered at least 28 calender days after the 1st dose. |
| • In lieu of immunization, written evidence of laboratory tests showing range of immunity to measles, mumps, rubella is acceptable. Attach written proof to the Certificate. |

<table>
<thead>
<tr>
<th>Vaccine</th>
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<th>#2</th>
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<tbody>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
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<tr>
<td>(Month, Day, Year)</td>
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</table>

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1</th>
<th>#2</th>
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</thead>
<tbody>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
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<tr>
<td>(Month, Day, Year)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
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</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(Month, Day, Year)</td>
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</tbody>
</table>

RECOMMENDED (Other) Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>OPV/IPV</td>
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<td></td>
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<table>
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<tr>
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<th>#3</th>
<th>#4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus-Diphtheria</td>
<td></td>
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<tr>
<td>DTaP or DTP and booster with Td</td>
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<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal</td>
<td></td>
</tr>
<tr>
<td>Quadrivalent polysaccharide vaccine</td>
<td></td>
</tr>
</tbody>
</table>

Tuberculosis Screening (See page 2 for detailed information)

1. PPD (Mantoux) within the past 6 months (tine or monovac not acceptable)
   Result: _______ (measured in mm of Induration). Please document 0 mm if no reaction

2. If PPD is positive (10mm or greater), chest X-ray required:
   X-ray result: Normal  Abnormal

3. If previously treated for TB, please submit copies of medical records indicating treatment & outcome of treatment.

If completed by physician
To the best of my knowledge, the person above has received the above immunizations

Signed _____________________________ Printed Name ______________________________ Date ______________
(Physician, nurse or school authority- Do not sign unless minimum requirement for MMR - measles, mumps and rubella - and Hepatitis B - are met)

AUTHORIZATION FOR MEDICAL TREATMENT

For All Students:
By signature, I verify that the information on this form is accurate and true. By signature I give permission for diagnosis, therapeutic, and operative procedures as may be deemed necessary for me.

Signature _____________________________ Printed Name _____________________________ Date ______________

For all students under 18 years of age:
I authorize the OSU Health Services to administer medical and surgical services, immunizations and therapeutic procedures as deemed necessary by duly licensed personnel.

Parent’s or Guardian’s Signature _____________________________ Relationship _____________________________ Date ______________