# IOWA STATE UNIVERSITY Thielen Student Health Center

## **IMMUNIZATION REQUIREMENTS - INTERNATIONAL STUDENT**

| LAST NAME                                | FIRST NAME | MIDDLE                      |  |  |
|------------------------------------------|------------|-----------------------------|--|--|
|                                          |            |                             |  |  |
| DATE OF BIRTH mm/dd/yyyy UNIVERSITY ID # |            | SEMESTER START (CHECK ONE): |  |  |
|                                          |            | □ FALL □SPRING □ SUMMER 20  |  |  |

#### **REQUIRED IMMUNIZATIONS**

**Measles:** Iowa State University requires that all new (including transfer and graduate) students born on or after January 1, 1957, show proof of immunization or immunity to measles. Measles immunizations may be found on your immunization record listed as Measles, MMR, MR, or Rubeola (titer).

| MEASLES                                                                                                                   | Vaccinne must be given at least 28 days apart and after 12 months of ag<br>less than the minimum interval or earlier than the minimum age are not v                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | · · ·                               | •                     |  |
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| Option 1                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     |                       |  |
| Measles                                                                                                                   | Dose 1 MMR Dose 1 mm/dd/yyyy   TYPE MR Image: Constraint of the second seco | Dose 1 MMR De<br>TYPE MR<br>MEASLES | ose 2 mm/dd/yyyy      |  |
| Option 2                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     |                       |  |
| Positive (+)<br>Rubeola IgG                                                                                               | mm/dd/yyyy mm/dd/yy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | уу                                  | □ Lab report attached |  |
| Option 3                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     |                       |  |
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| Submit proof of religious or medical exemption by attaching the appropriate lowa Department of Public Health Exemption to |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     |                       |  |
| this signed o                                                                                                             | document.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                     |                       |  |

#### **RECOMMENDED IMMUNIZATION**

Meningitis : The State of Iowa requires that all colleges and universities provide information on the meningitis vaccination to incoming students. If you will be living in the residence halls, it is recommended by the CDC that you receive this vaccination. This vaccination is not required, but it is recommended.

| Meningitis | mm/dd/yyyy | mm/dd/yyyy |
|------------|------------|------------|
| MCVY       |            |            |



### **IMMUNIZATION REQUIREMENTS - INTERNATIONAL STUDENT (PAGE 2/2)**

| LAST NAME FIRST NA       | ME MIDDLE       |  |  |
|--------------------------|-----------------|--|--|
|                          |                 |  |  |
| DATE OF BIRTH mm/dd/yyyy | UNIVERSITY ID # |  |  |
|                          |                 |  |  |

#### **TUBERCULOSIS SCREENING**

**Tuberculosis (TB)** is caused by a bacterium called mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal. For basic facts on tuberculosis, please visit the <u>Center for Disease</u> <u>Control and Prevention's tuberculosis page</u>.

It is <u>recommended by the CDC</u> for any incoming student who has traveled internationally to areas of high risk for tuberculosis, be screened for this illness. All incoming students will be prompted to answer questions regarding TB exposure below.

*lowa State University Thielen Student Health Center* follows the <u>World Health Organization</u> guidelines for TB testing. *lowa State does NOT require you to* complete testing prior to your arrival. If TB testing is indicated, it will be performed during your health screening orientation session.

| COUNTRY OF ORIGIN:                                                                                                                                                                                                                                              |                      |            |                 |            |                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------|-----------------|------------|---------------------|
| HISTORY OF                                                                                                                                                                                                                                                      | PREVIOUSTE           | BTESTING   |                 |            |                     |
| <b>IGRA</b><br>Interferon Gamma<br>Release Assay                                                                                                                                                                                                                | Result<br>□ Positive | □ Negative | □ Indeterminate | mm/dd/yyyy | Lab report attached |
| Treatment, if positive:                                                                                                                                                                                                                                         |                      |            |                 |            |                     |
| TB SKIN TEST                                                                                                                                                                                                                                                    | Result<br>□ Positive | □ Negative | □ Indeterminate | mm/dd/yyyy |                     |
| Treatment, if<br>positive:                                                                                                                                                                                                                                      |                      |            |                 |            |                     |
| Countries and dates traveled to in the last 5 years. Only include those where you stayed longer than 90 days, or stayed longer than 30 days and were a healthcare worker, refuge camp volunteer or prison worker.<br><u>Country of Origin Risk Status Chart</u> |                      |            |                 |            |                     |
|                                                                                                                                                                                                                                                                 |                      |            |                 |            |                     |
|                                                                                                                                                                                                                                                                 |                      |            |                 |            |                     |
|                                                                                                                                                                                                                                                                 |                      |            |                 |            |                     |
|                                                                                                                                                                                                                                                                 |                      |            |                 |            |                     |
|                                                                                                                                                                                                                                                                 |                      |            |                 |            |                     |

#### LICENSED MEDICAL PROVIDER VERIFICATION

Students can attach original and signed documents for immunizations/testing listed above in lieu of signature below. Original documents must be translated and include your name and date of birth.

|                        | First     | Last |       |  |
|------------------------|-----------|------|-------|--|
| Provider Printed Name  |           |      | Phone |  |
| Provider Signatures/Cr | edentials |      | Date  |  |