KENT STATE UNIVERSITY | University Health Services

SUBMIT THIS FORM TO:

Kent State University Health Services
1500 Eastway Drive, Kent OH 44242-0001
Phone (330) 672-8263 Fax (330) 672-2272 or Email: immunizations@kent.edu

Mandatory Student Immunization Requirements

Last Name: _____First Name: _____KSU ID# _____

Address _____Cell Phone_____

City _____ State _____Zip _____

Date of Birth _____ Birth Country _____ E-Mail _____

Students born before Jan. 1st, 1957 are exempt from Part I. *All other students must complete and submit Part I*
International students must also complete Part II.

PART I - MEASLES/MUMPS/RUBELLA (MMR VACCINE)

Requirement: TWO doses of MMR vaccine after the age of **one** and separated by at least one month

Date: #1 _____

#2 _____

-OR-

If immunizations were NOT given in the MMR combined vaccine – please indicate dates received:

Date: MEASLES #1 _____ MUMPS #1 _____ RUBELLA #1_____

MEASLES #2 _____ MUMPS #2_____ RUBELLA #2 _____

ALL IMMUNIZATION DATES **MUST** BE VERIFIED BY A PHYSICIAN OR HEALTH CARE PROVIDER

-OR-

A **COPY** OF YOUR IMMUNIZATION RECORD MUST BE ATTACHED TO THIS COMPLETED FORM

Healthcare provider's name and address:

_____ _____

Healthcare Provider Signature

_____

_____

PART II – TB SCREENING – *INTERNATIONAL STUDENTS ONLY*

Students from the following countries are required to have tuberculosis screening: Africa, Eastern Europe, Russia, Mexico, Central America, South America, Asia, the Middle East, the Pacific Islands and the Caribbean. This test must be completed within 12 months prior to starting classes.
(For a complete list of the World Health Organizations high risk countries visit World Health Organization Global Health Observatory)

☐ I was **not** born in or had an extended stay in any country listed above

Tuberculosis Skin Test (Mantoux): Date Given: _____Date Read :_____Results Required (millimeters)_____

If you previously received a **BCG** vaccine, a blood test such as **Quantiferon Gold** is the preferred test to indicate absence of TB.

Date:_____ Result (Check one) ☐ Positive ☐ Negative

If a current or past TB screening or Quantiferon Gold Test was positive, you will need to complete the following:

Chest X-ray date: _____ Result(Check one) ☐ Positive ☐ Negative

Treatment: ☐ YES ☐ NO – Document drug/dose/frequency_____ Date and length of treatment_____

Document reason prophylaxis or treatment not done_____

Healthcare Provider's Name and Address:_____

Healthcare Provider's Signature:_____