Indiana State University

# Office of the Registrar

**Phone: (812) 237-2020** **Fax: (812) 237-8039**

## Immunization Form

Please upload this completed form to indianastate.edu/secureupload or email registrar@indstate.edu

This form must be completed in **ENGLISH** and signed by (1) the student (parent or guardian if the student is under age 18.) The form should also be signed by a medical provider. If the form is not signed by a medical provider, you MUST submit: (a) a physician's certificate; (b) immunization records forwarded from another school or postsecondary institution; (c) a certificate record maintained by the student or parent of the student showing the month/day/year in which each dose of vaccine was administered; or (d) evidence of having met alternative criteria.

Last Name _____ First Name _____ Middle Name _____ University ID # (XXX-XX-XXXX) _____ Date of Birth (MM/DD/YYYY) _____

### Section 1: Measles/Mumps/Rubella

If you were born before 1957, you are considered immune to measles, mumps and rubella and are not required to complete this section. ALL students born in or after 1957 must complete either Box A, Box B, or Box C:

**Box A: MMR Vaccination**

**First measles vaccination must have been after 12 months of age, and the second must be at least 30 days after the first dose.**

MMR Dose #1:_____

MMR Dose #2:_____

**Box B: Separate Immunizations**

**First measles vaccination must have been after 12 months of age, and the second must be at least 30 days after the first dose.**

Measles Dose #1:_____

Measles Dose #2:_____

Mumps Dose #1:_____

Rubella Dose #1:_____

**Box C: Positive Antibody Titers**

**Copy of lab report must also be submitted.**

Measles Titer _____

Mumps Titer _____

Rubella Titer _____

### Section 2: Tetanus/Diphtheria Booster

**ALL** students must provide evidence of a tetanus/diphtheria booster given within the last 10 years:

Booster Date: _____

### Section 3: Meningitis

**Meningitis Conjugate- 1 dose**

- MCV4/Menactra®/Menveo® On or after 16th birthday, required of all incoming students 23 years of age or younger

Dose #1: _____

**AND**

**Meningococcal Group B**

Students who are 24 years old or younger must receive a **complete** Meningitis B series

**MenB-4C (Bexsero®)**

Two doses – six months apart

Dose #1: _____

Dose #2: _____

**OR**

**MenB-FHbp (Trumenba®)**

Two doses – six months apart

Dose #1: _____

Dose #2: _____

Vaccine series are not interchangeable

### Section 4: Tuberculosis

**ALL International students** are required to submit Tuberculosis (TB) screening information to Indiana State University. Students that are US Citizens are not required to submit this information. A QuantiFERON® blood test must be performed in the United States to be considered valid for Indiana State University. Testing is to be done within the first two weeks of the start of your first semester attending Indiana State University. Testing is available at the campus health center for a reasonable fee. Students must provide confirmation of taking the TB Test.

**For Medical Provider:** I attest the above information is correct and can be supported by medical records on file:

Medical Provider Signature _____ Medical Provider Printed Name _____ Date _____

**I have reviewed the above information and believe it to be accurate.**

Student Signature _____ Date _____ Parent/Guardian Signature (if student under age of 18) _____ Date _____