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
_____	_____	_____	_____