Official Notice: Immunization Requirements for Oklahoma State University Students

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 moral 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/. The requirement shall not apply to students enrolling in courses delivered via the Internet or distance learning in which the student is not required to attend class on campus.

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>See below*</td>
<td>At move in</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella, TWO DOSES</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>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 all new students living in campus housing be provided information regarding meningococcal disease and the availability of a vaccine that may prevent meningitis. This information will be sent from OSU Residential Life. As part of the housing contract, the student, (or parent in the case of a minor), will attest that he/she has either received the vaccine or chosen not to be immunized against meningitis. No additional documentation of this vaccination is required. This is part of the housing contract.

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 screening. This policy is explained on page 2 of this form.

Please bring this completed form with you to enrollment OR mail to:

OSU Stillwater Campus: Immunization Coordinator
OSU Health Services
1202 West Farm Road
Stillwater, OK 74078-2036
405-744-3252
FAX 405-744-6556

OSU Tulsa Campus: Immunization Coordinator
700 North Greenwood Ave.
North Hall 130
Tulsa, OK 74104
918-594-8147
FAX 918-594-8114
Tuberculosis Testing

Any student who meets any of the criteria below is required 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 U.S. student who has resided outside the U.S. for > 8 weeks continuously

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.

Tuberculosis Testing Procedure

Students who are required to be tested for TB should report to University Health Services, 1202 Farm Road to submit a blood sample for a newly developed test for tuberculosis. This does not require a return to the clinic for a second visit. This is a more accurate and reliable method of testing than a skin test and only requires one visit to the clinic.

If you have been treated for tuberculosis disease in the past provide a medical record indicating successful treatment for TB disease.

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

Please check one:
OSU Health Services Stillwater ___ OSU Tulsa ___
1202 West Farm Road 700 North Greenwood Ave.
Stillwater, OK 74078-2036 North Hall 130
405-744-7665 Tulsa, OK 74106
918-594-8147

NAME: __________________________________________________________________ Male ___ Female ___
(Last)                                   (First)                                    (Middle)

CWID # _______________________________________________________ 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/Urinary Infections
___

Brief Explanation of any CHECKED Responses: _____________________________________________________
____________________________________________________________________________________________

History of Surgery:   Yes    No         Ongoing Medical Problems:    Yes    No   (If Yes, List Below)
____________________________________________________________________________________________
____________________________________________________________________________________________

Environmental Allergies: __________________________    List current medications:

Medication Allergies:     Yes    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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Enter date each immunization was given</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>#1 #2</td>
<td>• Measles, mumps and rubella (MMR) vaccine is not required for college students born before January 1957.</td>
</tr>
<tr>
<td>(Month, Day, Year)</td>
<td></td>
<td>• The first MMR must have been given no earlier than 4 days before the first birthday. The 2nd dose of measles, mumps and rubella vaccine or of measles vaccine must have been administered at least 28 calendar days after the 1st dose.</td>
</tr>
<tr>
<td>Mumps</td>
<td>#1 #2</td>
<td>• 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.</td>
</tr>
<tr>
<td>(Month, Day, Year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>#1 #2</td>
<td></td>
</tr>
<tr>
<td>(Month, Day, Year)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hepatitis B

<table>
<thead>
<tr>
<th>Enter date each immunization was given</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Month, Day, Year)</td>
<td>#1</td>
</tr>
</tbody>
</table>

RECOMMENDED (Other) Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Enter date immunization was given</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>#1 #2</td>
<td></td>
</tr>
<tr>
<td>(Month, Day, Year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>OPV/IPV</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>Tetanus-Diphtheria</td>
<td>DTP or DTP and booster with Td</td>
<td></td>
</tr>
<tr>
<td>#1</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>Quadrivalent polysaccharide vaccine</td>
<td>#1</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
   OR
2. If PPD is positive (10mm or greater), chest X-ray required:
   X-ray result: Normal Abnormal _______
   OR
3. If you had a previous positive PPD, or had a BCG vaccine, a blood test will be required. You are responsible for the cost of this test.
   OR
4. 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 ____________________________  Title ____________________________  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 ______________