University Health Services

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 ***UHS.okstate.edu***. 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

Vaccination	Who must comply	Compliance Requirements	Compliance Date
Meningitis*	All new students living in campus housing	See below*	At move in
Measles, Mumps, Rubella, TWO DOSES	All new students born after January 1, 1957	Proof of vaccination with **2 doses** of vaccine; or lab test demonstrating immunity; or, signed Certificate of Exemption	End of the fourth week of classes
Hepatitis B	All new students	Proof of completion of a Hep B series or signed Certificate of Exemption	Minimum of first 2 shots by 6th week of class; completion of series by 4th week of the student's second semester

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 Screening

Who must comply?

- **Students currently holding a visa from the 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 screening requirement. For other students, this is a recommendation.

If the results of the screen indicate a risk for Tuberculosis, you will need to be tested. This test will only be accepted if done at University Health Services. The student is responsible for the cost of the Tuberculosis blood test.

Tuberculosis Testing Procedure

Students who are required to be screened for Tuberculosis should report to University Health Services, 1202 Farm Road, Stillwater OK, 74078. **If you have been treated for Tuberculosis disease in the past, provide a medical record indicating successful treatment for Tuberculosis or TB.**

Please note: Having received the BCG vaccination does NOT exempt you from the screening requirement. A chest x-ray does not satisfy the testing requirement.

EFFECTIVE OCTOBER 1, 2013; NO EARLIER VERSIONS OF THIS FORM ACCEPTED.

University Health Services

All new students must complete both sides of this form

Medical History

Please check one:

OSU Health Services Stillwater ___
1202 West Farm Road
Stillwater, OK 74078-2036
405-744-7665

OSU Tulsa ___
700 North Greenwood Ave.
North Hall 130
Tulsa, OK 74106
918-594-8147

Please indicate the first semester you attended
___ Fall
___ Spring
___ Summer

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: _____
_____

Medication Allergies: Yes No
(List Medication/Reaction) _____
_____
_____
_____

List current medications:
_____
_____
_____
_____
_____
_____
Herbs _____

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

Hepatitis B (Month, Day, Year)	#1	#2	#3

RECOMMENDED (Other) Immunizations

Hepatitis A (Month, Day, Year)	#1	#2	Polio OPV/IPV	#1	
Tetanus-Diphtheria DTaP or DTP and booster with Td	#1	#2	#3	#4	(Td) booster

Meningococcal Quadrivalent polysaccharide vaccine	#1

If completed by physician

To the best of my knowledge, the person above has received the above immunizations

Signed _____ Title _____ Date _____

Address _____ Phone_____ Fax_____

(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 _____