UNIVERSITY OF DAYTON HEALTH REQUIREMENTS

Return completed forms to University of Dayton Gosiger Health Center
300 College Park | Dayton, OH 45469-0900 | Phone: 937-229-3131 | Fax: 937-229-3107

Name____
First Middle Last

Address____

____
City State Zip Country

Cell Phone (_________) ____________________ Email_______________________________

Date of Birth_______/_______/_______ Age at the time you will enter the University_________

Student ID number (required)_____________________________

First term of Enrollment (circle) Fall Spring Summer I Summer II Year: 20_________

Please circle: Freshman Law/ Grad. Student Transfer International Student Commuter Online Class Only

THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

Required immunizations: This information **must** be submitted to avoid a **medical hold** on class registration.
Due July 1 for fall semester, Jan 1 for spring semester.

MMR (Measles, Mumps, Rubella): Two doses required for **all** students born in 1957 or later.

Dose 1– Given at age 12 months or later. Date of administration______/_______/_______

Dose 2– Given at least one month after the first dose. Date of administration______/_______/_______
Exemption: Students born before 1957 are exempt from this requirement. Proof of positive **MMR titer** results also satisfy the MMR requirement (**attach lab reports**).

HEALTH CARE PROVIDER (Signature or stamp required)

Name_______________________________ **Signature**______________________________
(Please print)

Address____

Phone (_________) ____________________ Date______________________________

Student name (print)_______________________________ Student ID #___________________________

Meningitis and Hepatitis B vaccines are strongly recommended. The state of Ohio **requires** that **all** students who plan to live on campus disclose whether or not they have been vaccinated against Meningitis and Hepatitis B or **sign** the vaccine disclosure statement (below).

Hepatitis B: Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____ (required for Doctor of Physical Therapy students)

Meningococcal vaccine: Menactra____/____/____ Menveo____/____/____ Menomune____/____/____

Declined meningitis or hepatitis B vaccination (student signature required, parent if student is under 18)
I have read the attached CDC guidelines and understand the associated risk of Meningococcal disease and Hepatitis B disease.

Signature_______________________________________ **Date**______________________________

OPTIONAL IMMUNIZATIONS

The following vaccines are strongly recommended, but are not required for admission.

1. Tetanus and Diphtheria (date of most recent): Tdap: ___/___/___ or Td: ___/___/___
(Tdap is **required** for students who will be working in childcare settings, including some Education students.)

2. HPV (Human Papillomavirus): Dose #1: ___/___/___ Dose #2 : ___/___/___ Dose #3 : ___/___/___

3. Hepatitis A: Dose #1: ___/___/___ Dose #2 : ___/___/___

4. Varicella: Dose #1: ___/___/___ Dose #2 : ___/___/___

5. Other vaccinations (e.g. oral typhoid for travel etc.) ____

TUBERCULOSIS (TB) QUESTIONNAIRE **Required for all students** (please circle response)

1. Have you had contact with a person with active TB? Yes No

2. Have you ever lived or worked in a nursing home, correctional facility (jail/prison), homeless shelter, hospital, or other healthcare facility? Yes No

3. Do you have a chronic medical condition or take medication that impairs the immune system? Yes No

4. Have you **ever** used illegal IV drugs or cocaine? Yes No

5. Were you **born in one of the countries listed below**, or spent more than 1 month visiting these countries? (If yes, please **circle** the country or countries, below) Yes No

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

(Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata)

IF YOUR ANSWERED YES TO TB QUESTIONS 1-5 OR CIRCLED ONE OR MORE COUNTRIES ABOVE, THE FOLLOWING INFORMATION IS REQUIRED WITHIN ONE YEAR PRIOR TO ARRIVAL.

Tuberculin Skin Test Date given: _____/_____/_____ Date read: _____/_____/_____
Result: ________mm Negative Positive **(Attach results)**

or TB blood test (IGRA such as T-spot or Quantiferon Gold) Negative Positive (Attach results)

Chest X-ray result (required if tuberculosis skin or blood test is positive): Date____/____/____ Normal Abnormal
(Attach results)