UNIVERSITY OF DAYTON HEALTH REQUIREMENTS
Return completed forms to University of Dayton Gosiger Health Center
300 College Park Dayton, Ohio 45469-0900 Phone 937-229-3131 Fax 937-229-3107

Name ____
First Middle Last
Address ____

____
City State Zip Country
Cell Phone (______) ________________ E-Mail ____

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: Freshmen 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 ___/___/___ Booster (recommended if > 5 years since 1st dose) ___/___/___

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 disesase.

Signature____ Date: __________

____

OPTIONAL IMMUNIZATIONS

The following vaccines are strongly recommended, but are not currently 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? Yes No
(If yes, please CIRCLE the country or countries, below)

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 you 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)**