Name (print) ______________________________________ Date of Birth ___/___/___ Student ID __________________________

Phone #________________________________________ Email __________________________

UNIVERSITY OF DAYTON HEALTH REQUIREMENTS
Required by Ohio law and/or University of Dayton.
300 College Park | Dayton, OH 45469-0900 | Phone: 937-229-3131 | Fax: 937-229-3107 | myhealth.udayton.edu

REQUIRED: (information must be submitted to avoid a medical Hold on class registration.)
Due July 14 for fall semester, January 1 for spring semester.

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

Dose 1 Given at 12 months or later ___/___/___ Dose 2 Given at least 28 days after first dose ___/___/___

*Proof of positive MMR titer results also satisfy the MMR Requirement (attach lab reports).

**CERTIFICATION BY HEALTHCARE PROVIDER** (signature, stamp or attached record)
Name/title __________________________________________ Signature __________________________ Date _________________

Address ___________________________________________________________________________ Phone __________________________

**STRONGLY RECOMMENDED:**
Meningitis and Hepatitis B vaccines are strongly recommended.

**HEPATITIS B VACCINE:**

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Mo Day Yr Mo Day Yr Mo Day Yr

**MENINGOCOCcal MENINGITIS VACCINE:**
(At least one dose at age ≥ 16)

Dose #1 ___/___/___ Dose #2 ___/___/___

Mo Day Yr Mo Day Yr

**MENINGOCOCcal GROUP B VACCINE:**

☐ Bexsero ☐ Trumenba

Dose #1 ___/___/___ Dose #2 ___/___/___

Mo Day Yr Mo Day Yr

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.

☐ I have read the information regarding Hepatitis B and meningitis on the CDC website www.cdc.gov/vaccines/hcp/vis/index.html. I understand the risk in not receiving the vaccine and have decided to decline vaccination at this time.

Student Signature (required) __________________________ Date _________________

Parent or Legal Guardian (if under 18) __________________________ Date _________________

RECOMMENDED:

**Tdap (Tetanus, Diphtheria, Pertussis) VACCINE:**

Last Booster done ___/___/___

Mo Day Yr

**HEPATITIS A VACCINE:**

#1 ___/___/___ #2 ___/___/___

Mo Day Yr Mo Day Yr

**VARICELLA VACCINE:**

#1 ___/___/___ #2 ___/___/___

Mo Day Yr Mo Day Yr

**HPV (Human Papillomavirus) VACCINE:**

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Mo Day Yr Mo Day Yr Mo Day Yr

**Polio**

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Mo Day Yr Mo Day Yr Mo Day Yr

#4 ___/___/___ #5 ___/___/___

Mo Day Yr Mo Day Yr
Tuberculosis (TB) Questionnaire – Required

1. Have you ever had close contact with persons known or suspected to have active TB?  
   ○ Yes  ○ No

2. Have you been a resident and/or employee in a high-risk setting (e.g., correctional facility, long-term care facility and homeless shelter)?  
   ○ Yes  ○ No

3. Have you been a volunteer or health care worker who served clients at increased risk for active TB disease?  
   ○ Yes  ○ No
   If yes, please explain ________________________________

4. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or drug or alcohol abuse?  
   ○ Yes  ○ No

5. Were you born in one of the countries listed below that have a high incidence of active TB disease or prolonged visits (more than one month)* to one or more of the countries listed below.  
   (If yes, please circle the country)
   ○ Yes  ○ No

   *The significance of the travel exposure should be discussed with a health care provider and evaluated.

   Afghanistan  Cote d’Ivoire  Iraq  Mongolia  Sierra Leone  Singapore
   Algeria  Djibouti  Kazakhstan  Morocco  Somalia
   Angola  Dominican Republic  Kenya  Mozambique  South Africa
   Armenia  Ecuador  Kiribati  Myanmar (Burma)  Namibia
   Azerbaijan  El Salvador  Korea-People’s Rep (North)  Nauru  Nepal
   Bangladesh  Equatorial Guinea  Korea-Republic of (South)  Nicaragua  Nepal
   Belarus  Eritrea  Kyrgyzstan  Nigeria  Nigeria
   Benin  Ethiopia  Lao  Northern Mariana Islands  Pakistan
   Bhutan  Fiji  Latvia  Palau  Palau
   Bolivia  Gabon  Lesotho  Panama  Panama
   Botswana  Gambia  Liberia  Paraguay  Paraguay
   Brazil  Georgia  Libya  Peru  Philippines
   Brunei Darussalam  Ghana  Lithuania  Poland  Romania
   Burkina Faso  Greenland  Macau (SAR of China)  Russian Federation  Rwanda
   Burundi  Guam  Madagascar  Sao Tome and Principe
   Cambodia  Guinea  Malawi  Senegal  Seychelles
   Cameroon  Guinea-Bissau  Malaysia  Serbia  Singapore
   Cape Verde  Guyana  Maldives  Slovakia  Solomon Islands
   Central African Republic  Haiti  Mali  Slovenia  South Africa
   Chad  Honduras  Marshall Islands  South Sudan  South Korea
   China (including Taiwan)  Hong Kong (SAR of China)  Mauritania  Sri Lanka  Spain
   Congo  India  Mauritius  Sudan  Sri Lanka
   Congo-Democratic Republic  Indonesia  Micronesia  Sweden  Swaziland

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:

TB Blood Test (preferred; REQUIRED if TB skin test is positive)  
   (IGRA such as T-spot or Quantiferon Gold):  Negative  Positive  (Attach result)

Or tuberculin skin test: Date given: __/__/__  Date read: __/__/__

Result: _________ mm  Negative  Positive  (Attach result)

Chest X-ray result (required if tuberculosis skin or blood test is positive):

Date: __/__/__  Normal  Abnormal  (Attach result)

Mail or fax completed form to the University of Dayton Health Center
300 College Park | Dayton, OH 45469-0900 | Phone: 937-229-3131 | Fax: 937-229-3107