THE OHIO STATE UNIVERSITY
OFFICE OF STUDENT LIFE

STUDENT HEALTH SERVICES

LICENSED MEDICAL PROVIDER (MD, DO, PA, NP, RN): Return completed form to student.

STUDENT: UPLOAD completed form to MyBuckMD OR **email** to vaccination@osu.edu OR **fax** to 614-292-7042 OR **mail** to Health Information Services, 1875 Millikin Rd., Columbus, OH 43210

INTERNATIONAL - Vaccination Requirement

Last Name	First	Middle

Date of Birth mm/dd/yyyy	University ID Number (8 or 9 digits)	Semester Start (check one): ☐ Fall ☐ Spring ☐ Summer 20____

Country of Birth	Country of Citizenship

Country(ies) lived in or visited 3 months prior to arrival in United States

INTERNATIONAL

These vaccines are **required** if you are new to The Ohio State University.

Hepatitis B Three (3) doses of Hepatitis B [at least 28 days between Dose 1 and Dose 2 and at least 20 weeks between Dose 2 and Dose 3] OR blood titer lab report confirming immunity.

Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	Dose 3 mm/dd/yyyy	OR	☐ Lab report confirming immunity attached

Measles-Mumps-Rubella Two (2) doses of MMR OR two (2) doses of Measles, two (2) doses of Mumps, and one (1) dose of Rubella [each dose must be on or after one year (12 months) of age, with at least 28 days between Dose 1 and Dose 2] OR blood titer lab report confirming immunity for each.

	Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy		
MMR				
OR				
Measles	Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	**OR**	☐ Lab report confirming immunity attached
Mumps	Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	**OR**	☐ Lab report confirming immunity attached
Rubella	Dose 1 mm/dd/yyyy		**OR**	☐ Lab report confirming immunity attached

Polio Four (4) doses of IPV or OPV. Only required if you will be younger than eighteen (18) years of age at the start of the semester.

Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	Dose 3 mm/dd/yyyy	Dose 4 mm/dd/yyyy

Tetanus-Diphtheria-Pertussis (Tdap) One (1) dose of Tdap within the past ten (10) years.

mm/dd/yyyy	

Varicella Two (2) doses of varicella [each dose must be on or after one year (12 months) of age, with at least 28 days between Dose 1 and Dose 2] OR blood titer lab report confirming immunity *("history of the disease" is not acceptable, a lab report is required if there is a history of the disease).*

Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	OR	☐ Lab report confirming immunity attached

HOUSING

This vaccine is **required** if you are new to University Housing at The Ohio State University.

Meningococcal conjugate (ACWY) One (1) dose since age 16. Only a dose on or after the 16th birthday will be accepted.

mm/dd/yyyy

(continued on second page) ➡

INTERNATIONAL - Vaccination Requirement *(continued)*

Last Name	First	Middle

Date of Birth mm/dd/yyyy	University ID Number (8 or 9 digits)

INTERNATIONAL

This section is **required** if you are an international student with an F-1 or J-1 student visa who is new to The Ohio State University.

BCG Vaccine - if applicable

Date Given mm/dd/yyyy

Chronic Health Problems (Please list and explain) ☐ **No chronic health problems**

Tuberculosis Test – Required A skin test **OR** blood test completed no more than six (6) months prior to the semester start date.

Skin Test	Date Given mm/dd/yyyy	Date Read mm/dd/yyyy	Result ☐Positive ☐Negative ☐Indeterminate	Induration
	OR			
Blood Test	Date of Test mm/dd/yyyy		Result ☐Positive ☐Negative ☐Indeterminate	

Health Questions – Required

Since your last Tuberculosis test, have you:

Worked or lived with someone with active Tuberculosis (or will you prior to your arrival in the United States)?	☐Yes ☐No	If Yes, explain:
Had current Tuberculosis symptoms for more than 3 weeks (cough, pain in chest, coughing up blood or sputum, weakness or fatigue, weight loss, no appetite, chills or fever)?	☐Yes ☐No	If Yes, explain:
Had problems with your immune system?	☐Yes ☐No	If Yes, explain:

LICENSED MEDICAL PROVIDER (MD, DO, PA, NP or RN*) VERIFICATION *(required)*

Provider Printed Name First Last

Phone _____

Provider Signature/Credentials _____

Date m m / d d / y y y y

(Must be signed by MD, DO, PA, NP or RN*)

Office Stamp:

office stamp **required for RN signatures*