THE OHIO STATE UNIVERSITY
OFFICE OF STUDENT LIFE

STUDENT HEALTH SERVICES
WILCE STUDENT HEALTH CENTER

Health Information Services
1875 Millikin Rd., Columbus, OH 43210
614-292-0118 Office / 614-292-7042 Fax
vaccination@osu.edu

Once this form is completed by your licensed medical provider, follow the Vaccination *Requirement – Instructions available* at shs.osu.edu, under "Forms" and "Vaccination Requirement".

Vaccination Requirement – INTERNATIONAL

Last Name	First Name	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

These vaccines are **required** if you are new to The Ohio State University's Columbus campus.

Hepatitis B

Given in a series with at least 4 weeks between the first and second doses, at least 8 weeks between the second and third doses and at least 16 weeks between the first and third doses OR positive Hepatitis B antibody titer (**laboratory report must be attached**). Doses administered at less than the minimum intervals are not valid and must be repeated.

☐ **2-Dose Heplisav** **or** ☐ **3-Dose**

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 doses given at least 28 days apart and after 12 months of age. If given as single antigen vaccines, 2 Measles, 2 Mumps and 1 Rubella dose required OR positive MMR antibody titer (laboratory report must be attached). Doses of Varicella and MMR must be given on the same day or 28 days apart. Doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated.

MMR **Dose 1** MM/DD/YYYY **Dose 2** MM/DD/YYYY

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

Meningococcal Conjugate (ACWY)

One dose since age 16. Only a dose on or after the 16th birthday will be accepted. Do not complete this section if you will be over 22 years of age at the start of your first semester. The Meningococcal B vaccine does not fulfill the requirement.

Dose 1 MM/DD/YYYY

Polio

Four doses of IPV or OPV. Do not complete this section if you will be over 18 years of age at the start of your first semester. Polio only required if you will be younger than 18 years of age at the start of the first 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 dose of Tdap since age 11 and within the last ten years OR one dose of Tdap since age 11 and one dose of TD within the last ten years.

Tdap MM/DD/YYYY **Td** MM/DD/YYYY

Varicella

Two doses given at least 28 days apart and after 12 months of age OR positive Varicella antibody titer (**laboratory report must be attached**). Doses of Varicella and MMR must be given on the same day or 28 days apart. Doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated. **Documentation of disease history does not fulfill the requirement.**

Dose 1 MM/DD/YYYY **Dose 2** MM/DD/YYYY **OR** ☐ Lab report confirming immunity attached

(Continued on second page)

INTERNATIONAL - Vaccination Requirement (continued)

Last Name	First Name	Middle

Date of Birth MM/DD/YYY	University ID Number (8 or 9 digits)

INTERNATIONAL - Tuberculosis Test

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 - provide date if applicable. *Not all countries administer this vaccine.*

Date Given MM/DD/YYYY

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

Tuberculosis Test	A Tuberculin skin test OR Interferon Gamma Release Assay (IGRA) blood test must be completed no more than six (6) months prior to the semester start date. Tuberculosis testing and doses of Varicella and/or MMR must be given on the same day or 28 days apart. Testing done at less than the minimum interval is not valid and must be repeated.		
Tuberculosis Skin Test	**Date Given** MM/DD/YYYY **Date Read** MM/DD/YYYY	Result ☐ Positive ☐ Negative ☐ Indeterminate	**Induration** (recorded in mm)
OR			
IGRA Blood Test	**Date of Test** MM/DD/YYYY	Result ☐ Positive ☐ Negative ☐ Indeterminate	

Health Questions

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)*

First Name Last Name

Provider Printed Name _____ Phone _____

Provider Signature/Credentials _____ Date _____

(**Must be signed by MD, DO, PA, NP or RN***) M M / D D / Y Y Y Y

Office Stamp:
Office stamp **required** for RN signatures