THE OHIO STATE UNIVERSITY
OFFICE OF STUDENT LIFE

STUDENT HEALTH SERVICES

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 as a PDF at shs.osu.edu, under "Forms", under "Vaccination Requirement".

INTERNATIONAL and/or HOUSING - 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 *(if applicable)*

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

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.

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

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 since age 11 and within the last ten (10) years **OR** One (1) dose of Tdap since age 11 and one (1) dose of Td within the last 10 years.

Tdap	mm/dd/yyyy	**Td**	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 *(if applicable)*

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. The Meningococcal B vaccine does not fulfill this requirement.

mm/dd/yyyy

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INTERNATIONAL - Vaccination Requirement *(continued)*

Last Name	First	Middle

Date of Birth mm/dd/yyyy	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 – 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*