UNIVERSITY OF DAYTON HEALTH REQUIREMENTS
Required by Ohio law and/or University of Dayton. UPLOAD forms to student portal: myhealth.udayton.edu
300 College Park | Dayton, OH 45469-0900 | Fax: 937-229-3107
Any questions concerning health requirements – visit FAQ: go.udayton.edu/healthcenter or email us at healthcenter@udayton.edu.

REQUIRED: (information must be submitted to avoid a medical hold on next class registration.)
Due June 7 for fall semester, January 1 for spring semester.
*If you would like to request an exemption, e-mail healthcenter@udayton.edu to receive an exemption request form.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Due Date</th>
<th>Requirement Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (Measles, Mumps, Rubella) VACCINE:</td>
<td></td>
<td>Two doses required for all students born in 1957 or later.</td>
</tr>
<tr>
<td>Dose 1 Given at 12 months or later</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose 2 Given at least 28 days after first dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Proof of positive MMR titer results also satisfy the MMR Requirement (attach lab reports).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CERTIFICATION BY HEALTHCARE PROVIDER (signature, stamp OR attach/upload records)
Name/title ________________________________ Signature ________________________________ Date ________________
Address ____________________________________________________________________________ Phone #______________________________

STRONGLY RECOMMENDED:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1 Due Date</th>
<th>#2 Due Date</th>
<th>#3 Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEPATITIS B VACCINE:</td>
<td></td>
<td></td>
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<tr>
<td>MENINGOCOCCAL MENINGITIS VACCINE:</td>
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<tr>
<td>Dose #1 Given at age ≥ 16</td>
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<tr>
<td>MENINGOCOCCAL GROUP B VACCINE:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dose #1</td>
<td></td>
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</tr>
</tbody>
</table>

The State of Ohio requires all students who plan to live on campus disclose whether they have been vaccinated against meningitis and Hepatitis B, or sign the vaccine disclosure statement below.

☐ I have read the information regarding Hepatitis B at 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. Check box and sign.

☐ Check box if not living in university housing.

Student Signature (required) ________________________________ Date ________________

Parent or Legal Guardian (if under 18) ________________________________ Date ________________

RECOMMENDED:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1 Due Date</th>
<th>#2 Due Date</th>
<th>#3 Due Date</th>
<th>#4 Due Date</th>
<th>#5 Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap (Tetanus, Diphtheria, Pertussis) VACCINE:</td>
<td></td>
<td></td>
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<tr>
<td>HEPATITIS A VACCINE:</td>
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<tr>
<td>VARICELLA VACCINE:</td>
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<tr>
<td>HPV (Human Papillomavirus) VACCINE:</td>
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<tr>
<td>Polio (4 or 5)</td>
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</tbody>
</table>

Page 1 of 2  health form 2/17/2022
REQUIRED – TUBERCULOSIS (TB) QUESTIONNAIRE – Complete All questions and submit.

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.  ○ Yes ○ No
   (If yes, please CIRCLE the country)

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

Afghanistan  Columbia  Honduras  Myanmar  South Africa
Algeria  Comoros  India  Namibia  South Sudan
Angola  Congo  Indonesia  Nauru  Sri Lanka
Anguilla  Cote d’Ivoire  Iraq  Nepal  Sudan
Argentina  Dem People’s Rep of Korea  Kazakhstan  Nicaragua  Suriname
Armenia  Democratic Republic of Congo  Kenya  Niger  Swaziland
Azerbaijan  Djibouti  Kiribati  Nigeria  Tajikistan
Bangladesh  Dominican Republic  Kwait  Northern Mariana Islands  Tanzania (United Republic of)
Belarus  Ecuador  Kyrgyzstan  Pakistan  Thailand
Belize  El Salvador  Lao People’s Democratic Republic  Palau  Timor-Leste
Benin  Equatorial Guinea  Latvia  Panama  Togo
Bhutan  Eritrea  Lesotho  Papua New Guinea  Tunisia
Bolivia (Plurinational State of)  eSwatini  Liberia  Paraguay  Turkmenistan
Botswana  Ethiopia  Libya  Peru  Tuvalu
Brazil  Fiji  Lithuania  Philippines  Uganda
Brunei Darussalam  French Polynesia  Madagascar  Qatar  Ukraine
Bulgaria  Gabon  Malawi  Republic of Korea  Uruguay
Burkina Faso  Gambia  Malaysia  Republic of Moldova  Uzbekistan
Burundi  Georgia  Maldives  Romania  Vanuatu
Cabo Verde  Ghana  Mali  Russian Federation  Venezuela (Bolivarian Republic of)
Cameroon  Greenland  Marshall Islands  Rwanda  Viet Nam
Cambodia  Guan  Mauritania  Sao Tome and Principe  Yemen
Cameroon  Guam  Micronesia (Federated States of)  Sierra Leone  Zimbabwe
Central African Republic  Guatemala  Mexico  Senegal  Somalia
Chad  Guinea  Mongolia  Singapore
China  China, Hong Kong SAR  Guayana  Morocco  Solomon Islands
China, Macao SAR  Haiti  Mozambique  Somalia

IF YOU ANSWERED YES TO TB QUESTIONS 1-5 OR CIRCLED ONE OR MORE COUNTRIES ABOVE:

• Have a Tuberculin Skin Test or TB Blood Test (Quantiferon Gold or T-Spot).
• Testing must be done by a U.S. Licensed Healthcare Provider and within six months prior to initial attendance. Must ATTACH RESULTS.
• The TB Skin Test interpretation should be based on mm of induration as well as risk factors. A positive or borderline Quantiferon Gold or T-Spot requires a Chest X-ray. If a TB Skin Test or TB Blood Test is positive, please attach Chest X-ray, Laboratory Report and/or TB Treatment.
• Students may be tested at the Student Health Center upon arrival.

Upload completed form to the University of Dayton Health Center Student Portal: myhealth.udayton.edu
300 College Park | Dayton, OH 45469-0900 | Phone: 937-229-3131 | Fax: 937-229-3107