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 June 7 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 |
| / / Mo Day Yr | / / Mo Day Yr |

*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 BVACCINE:**

☐ Bexsero  ☐ Trumenba

| Dose 1 | Dose 2 |
| / / Mo Day Yr | / / Mo Day Yr |

**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 |

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

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