STUDENT ID NUMBER ______________________ **NAME** ____
(Please print) First Middle Last

Immunization Form

Please Return Form by August 1 to:

Capital University Center for Health and Wellness
1 College and Main
Columbus, OH 43209-2394
chw@capital.edu
Phone: 614-236-6114 Fax: 614-236-6980

Required Immunizations:

Tetanus, Diptheria, Pertussis: within the last 10 years Last Booster ______________________
(mm) (dd) (yy)

Measles, Mumps, and Rubella: two immunizations Dose1 ______________________
(mm) (dd) (yy)

Dose2 ______________________
(mm) (dd) (yy)

Polio: Completed primary series of polio immunizations Yes ☐ No ☐

Last Booster (if applicable) ______________________
(mm) (dd) (yy)

RECOMMENDED:

Covid-19 Vaccine received: Yes ☐ No ☐

If yes, please give dates: 1st dose ______________ 2nd dose: ____________________

Meningoccocal and Hep. B Status Form Completed (page 2) Yes ☐ No ☐

Tuberculosis Questionnaire Completed (page 3) Yes ☐ No ☐

Health Care Provider (M.D., D.O., N.P.)

Provider's Signature ____ Date ____________________

Provider's Name *(Please print)* ____

HEALTH CARE PROVIDER STAMP

STUDENT ID NUMBER ______________________ **NAME** ____
(Please print) First Middle Last

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Meningoccocal and Hepatitis B Status Form

Required State of Ohio Form for all Capital University Students

It is required by the State of Ohio Revised Code Section 3701.133, (B), that you **complete this form** for our files. You are not required to have these immunizations to enter the university but you must list whether you've had them or not. The Center for Health and Wellness strongly recommends that college students receive these im-munizations.

Meningoccocal Vaccine received: Yes ☐ No ☐

If yes, please give date: ______________________

Hepatitis B vaccine received: Yes ☐ No ☐

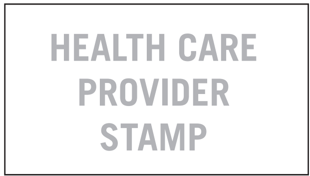
If yes, please give dates:

1st Dose ________________ 2nd Dose ________________ 3rd Dose ________________

Health Care Provider (M.D., D.O., N.P.)

Provider's Signature ____ Date ________________________

Provider's Name ____
(Please print)



☐ 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.

Student Signature (required) ____ Date ____________________

Parent/Legal Guardian (if student under age 18) ________________________________ Date____________________

STUDENT ID NUMBER ____________________ **NAME** ______________________________________
(Please print) First Middle Last

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Tuberculosis Screening Questionnaire

All Capital University students are required to provide information about overseas travel and possible exposure to tuberculosis (TB) prior to the start of classes. If you have been overseas, you should be tested for TB within 8-10 weeks after returning to the United States.

If you answer YES to any of the questions below, Capital University requires that you receive a TB skin test prior to starting school. If you are an international student, please make an appointment with the Center for Health and Wellness to discuss further testing as soon as possible. If the answer to all of the questions below is NO, no further testing or further action is required. Previous BCG vaccination does not exempt you from TB testing.

Have you ever had a **positive** TB test? ______________ Yes ☐ No ☐
Date test completed

Were you born in or have you lived in or traveled to a country **OTHER** than those listed below? Yes ☐ No ☐

If so, give name of country ______________________ Dates of travel ____________________

American Regions Canada Jamaica St. Kitts & Nevis US Virgin Islands St. Lucia

European Regions Belgium Denmark Finland Germany Greece Iceland Ireland Italy Liechtenstein Malta UK Monaco Norway Netherlands San Marino Switzerland

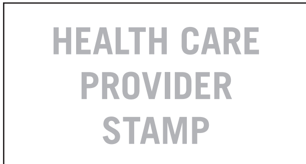
Western Pacific Regions American Samoa Australia New Zealand

Have you ever been vaccinated with BCG? Yes ☐ No ☐

Have you had any of the following symptoms?
- 3 weeks of unexplained cough or bloody sputum? Yes ☐ No ☐
- Unexplained night sweats, weight loss or fever? Yes ☐ No ☐

Do you have any of the following risk factors to TB infection:
- Cancer or long-term immunosuppressive therapy or steroids? Yes ☐ No ☐
- Use of illegal drugs? Yes ☐ No ☐
- Close contact with an active TB patient? Yes ☐ No ☐
- HIV infection or AIDS? Yes ☐ No ☐
- Recent resident or employee of correctional facility, nursing home, homeless shelter or health care setting? Yes ☐ No ☐

** Detailed information about screening and treatment for TB can be found at the following websites:* **www.cdc.gov/TB** and **www.acha.org/topics/tb.cfm.**



Provider's Name ______________________
(Please print)

Provider's Phone ______________________