ALLIED MEDICAL PROFESSIONS

IMMUNIZATION AND HEALTH SCREEN

OSU Student Health Services
1875 Millikin Road
Columbus, Ohio 43210-2200

____________________ Name

____________________ OSU e-mail address

HIMS Division

____________________ Birthdate

Please have form completed by your physician or attach proper documentation. Needed health screen requirements may be completed at the OSU Student Health Services. To schedule appointments at Student Health call 614-292-4321. If you have questions, please contact the Preventive Medicine Nurse, Monday – Friday at 614-292-0146; E-mail preventivemedicine@studentaffairs.osu.edu; or FAX 614-292-6001 or 24 hour confidential FAX: 614-292-7042.

PRIVACY INFORMATION: Student Health Services will exchange health information with your academic program only for purposes of determining compliance with program requirements under the Family Educational Rights and Privacy Act (FERPA).

IMMUNIZATION RECORD AND HISTORY OF PAST INFECTION—REQUIRED

1) **MMR** (Measles, Mumps, Rubella)

Vaccine dates: #1________________
#2________________

OR individual vaccine dates:

Measles (2 doses required): #1________________
#2________________

Mumps (one dose required) ________________

Rubella (one dose required) ________________

NOTE: Positive serum antibody titers are acceptable in place of Documented vaccines; please attach copy of lab reports

2) **Varicella** (chicken pox)

Copy of positive serum antibody titer
OR Vaccine dates: #1________________
#2________________

3) **Tetanus/Diphtrheria (Tdap recommended if booster due)** (booster required every 10 years)

Date of most recent booster:________________ Type____________

ADDITIONAL INFORMATION: (REQUIRED)

2-step TUBERCULIN SKIN TEST: PPD testing done may be scheduled at SHS. Testing done elsewhere must meet the following criteria:

-Must be within 3 months of matriculation (unless previous positive)
-Must be **MANTOUX** (intradermal) PPD tests
-Must be read by health care provider and result documented in mm.
-*For previous positive, please send documentation along with PA chest x-ray report within past year*

#1 PPD Date given:__________	#2 PPD Date given_____________
#1 PPD Date read:__________	#2 PPD Date read_____________
Result:__________mm.	Result:______________mm.
Read by:__________________	Read by:____________________

Influenza Vaccine is recommended for all health care workers.

HEALTH PROVIDER INFORMATION:

Please print name, address, and phone number:

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Signature