

**ALLIED MEDICAL PROFESSIONS**

**IMMUNIZATION AND HEALTH SCREEN**

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

\_\_\_\_\_  
Name OSU e-mail address **Med Diet**  
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](mailto: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 \_\_\_\_\_

NAME \_\_\_\_\_

**ADDITIONAL INFORMATION: (REQUIRED)**

**2-step TUBERCULIN SKIN TEST:** PPD testing 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: _____

**RECOMMENDED**

**Tetanus/diphtheria (Tdap recommended if booster due)**

Date of most recent booster: \_\_\_\_\_ Type \_\_\_\_\_

**Hepatitis B vaccine, series of 3**

#1 \_\_\_\_\_ #2 \_\_\_\_\_, #3 \_\_\_\_\_

**Influenza Vaccine** is recommended annually for all health care workers.



**HEALTH PROVIDER INFORMATION:**

Please print name, address, and phone number:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature