Kent State University Health Services
SUBMIT THIS FORM TO: 1500 Eastway Drive, Kent OH 44242-0001
Phone (330) 672-8263 Fax (330) 672-2272
Email: immunizations@kent.edu

Mandatory Student Immunization Requirements

Last Name_____First Name_____Kent State ID# _____

Address _____Cell Phone_____

City _____ State _____Zip _____

Date of Birth _____ Birth Country _____ E-Mail _____

Students born before Jan. 1st, 1957 are exempt from Part I. *All other students must complete and submit Part I.*
International students must also complete Part II.

PART I - MEASLES/MUMPS/RUBELLA (MMR VACCINE)

Requirement: TWO doses of MMR vaccine after the age of one and separated by at least one month

Date: #1 _____

#2 _____

If immunizations were NOT given in the MMR combined vaccine – please indicate dates received:

Date: MEASLES #1 _____ MUMPS #1 _____ RUBELLA #1_____

MEASLES #2 _____ MUMPS #2_____ RUBELLA #2 _____

ALL IMMUNIZATION DATES **MUST** BE VERIFIED BY A PHYSICIAN OR HEALTH CARE PROVIDER
-OR-
A **COPY** OF YOUR IMMUNIZATION RECORD MUST BE ATTACHED TO THIS COMPLETED FORM

Healthcare provider's name and address:

_____ _____
Healthcare Provider Signature

_____

_____ _____

PART II – TB SCREENING – INTERNATIONAL STUDENTS ONLY

Students from the following countries are required to have a tuberculosis screening test (TB test – Mantoux-type); Africa, Eastern Europe, Russia, Mexico, Central America, South America, Asia (including the Middle East, the Pacific Islands and the Caribbean). This test must be completed within 12 months prior to starting classes.

(For a complete list of WHO (World Health Organization) high risk countries visit our website @ www.kent.edu/uhs)

☐ I was not born in or had an extended stay in any country listed above.

TB Test (Mantoux): Date Given: _____ Date Read: _____ Results (record in millimeters): _____

Chest X-ray (required if TB test is positive or student has a history of positive TB test): Chest X-ray Date: _____ Results: _____

Treated with Anti-tuberculosis drug? ☐ YES ☐ NO

Healthcare provider's name and address:

_____ _____
Healthcare Provider Signature

_____