

Marquette University Student Health Service
A Division of Student Affairs

Schroeder Complex, Lower level
P.O. Box 1881
Milwaukee, WI 53201
PHONE: 414-288-7184 FAX: 414-288-5681
Email: immunizations@marquette.edu

**MARQUETTE UNIVERSITY REQUIRED IMMUNIZATION RECORD,
TUBERCULOSIS SCREENING AND MEDICAL HISTORY FORM**

Welcome to Marquette University. The Student Health Service (SHS) provides students with a broad range of primary care, health promotion and disease prevention services. The SHS website provides helpful details: www.marquette.edu/shs

Enclosed you will find a pre-matriculation Immunization Record, Tuberculosis Screening and Medical History Form. Marquette University **requires** all newly admitted or readmitted undergraduate, graduate, professional and transfer students to submit proof of the following:

- **1 Tetanus-Diphtheria Booster within the past 10 years**
- **2 MMR (measles, mumps, rubella) Vaccines OR 2 Measles, 1 Mumps, 1 Rubella Vaccine;**
Dose 1 on or after the first birthday; Dose 2 must be at least one month after the 1st dose.
If immunization date is not available, a laboratory report of a blood test (titer) showing immunity will be accepted.
Vaccine/Titer not required for those born prior to 1957.
- **History of Chickenpox Disease OR Varicella Vaccine OR positive blood Titer**
Two doses of vaccine if given after 13 years of age or 1 dose if given before 13 years of age
- **Tuberculosis Screening Questionnaire and results of Tuberculosis Testing/PPD if indicated**

In order to avoid delays, complete these forms or see your healthcare provider as soon as possible, especially if your immunizations are incomplete, and to get any required immunizations. Required immunizations are available from your healthcare provider, local health departments or the Marquette Student Health Service. You may contact SHS to arrange an appointment for any necessary immunizations and tests.

The information you submit will be maintained by the Student Health Service and will not be released to anyone without your knowledge and consent.

HEALTH SCIENCE, DENTAL, AND NURSING STUDENTS may be required by their department to receive additional immunizations. **Contact your department for specifications.**

Please return your completed forms to the address noted above 30 days prior to the start of your first session /term or immediately upon your arrival at Marquette University. **Failure to return your completed forms within 30 days after the start of your first session/term at Marquette will result in a medical hold preventing future registrations.**

Questions may be directed to: immunizations@marquette.edu or by calling the SHS at 414-288-7184.

PLEASE COMPLETE ALL PARTS OF THIS FORM AND MAKE A COPY OF THESE FORMS BEFORE SUBMITTING.

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Self-Reported Immunization Record

SHS use only Date Received ___/___/___
MMR #1 ___#2___ Td___ Varicella___ TB___
Complete Y N Entered Y N
Reviewed by: ___ Date Hold Removed: ___

Effective in the Fall of 2006, all newly admitted or readmitted students are required to return this completed form to Student Health Services at the address above within 30 days of the start of the session/term of enrollment. Failure to show proof of immunizations will result in a block in your registration for subsequent sessions/terms.

LAST NAME (print) FIRST NAME MIDDLE GENDER: [] M [] F
DATE OF BIRTH COUNTRY OF BIRTH MARQUETTE ID # (MUID #) MU EMAIL
PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

CLASS YOU ARE ENTERING (circle): UNDERGRAD GRAD PROF NON-DEGREE SEMESTER/TERM ENTERING (circle): FALL SPRING SUMMER OTHER: ENTRANCE YEAR

REQUIRED IMMUNIZATIONS

Please complete this form as soon as possible. You may obtain dates/documentation from your health care provider or previous school records. If documentation/data is unavailable, a laboratory report of a blood test (titer) to determine level of immunity or re-immunization is required. Immunizations are available at the Marquette University Student Health Service for a fee. Call (414) 288-7184 for an appointment.

1. TETANUS/DIPHTHERIA

Booster dose within 10 years Booster: ___/___/___ (mos) (day) (year)

2. MMR (measles, mumps, rubella)

Immunization with two doses of MMR, given on or after first birthday and separated by at least one month

MMR #1 ___/___/___ MMR #2 ___/___/___ (mos) (day) (year) (mos) (day) (year)

OR

Measles #1 ___/___/___ Measles #2 ___/___/___ or attached lab report showing positive immunity___ (mos) (day) (year) (mos) (day) (year)

Mumps ___/___/___ (Date of last dose.) or attached lab report showing positive immunity___ (mos) (day) (year)

Rubella ___/___/___ (Date of last dose.) or attached lab report showing positive immunity___ (mos) (day) (year)

3. VARICELLA

History of chickenpox disease, immunization or positive titer

Date of Chickenpox Disease ___/___/___ or attached lab report showing positive immunity___ (mos) (year)

OR

Varicella #1 ___/___/___ Varicella #2 ___/___/___ (mos) (day) (year) (mos) (day) (year)

RECOMMENDED IMMUNIZATIONS
Meningitis Vaccine Dose: ___/___/___
Hepatitis B Series of 3 doses; 0, 1, 6 months Date #1: ___/___/___ Date #2: ___/___/___ Date #3: ___/___/___
Polio Three doses Date #1: ___/___/___ Date #2: ___/___/___ Date #3: ___/___/___

I HAVE READ AND UNDERSTAND THE IMMUNIZATION REQUIREMENTS OF THIS FORM AND THE ENCLOSED INFORMATION. This form has been truthfully completed to the best of my knowledge and I freely consent to this form being used for my treatment at Marquette University.

Student Signature: _____ Date: _____

Parent Signature (if under 18 years of age): _____ Date: _____

TUBERCULOSIS QUESTIONNAIRE

All newly admitted students are required to submit this completed form to the Student Health Service within 30 days of the start of the session/term of enrollment

NAME: _____ **MU ID#:** _____ **DATE:** _____

To answer the following questions, please refer to the list below which details the list of countries with high rates of TB.*

Afghanistan	Chad	Guinea	Macao SAR	Nigeria	Sri Lanka
Angola	China	Guinea-Biss	Macedonia	Niue	Sudan
Armenia	Columbia	Guyana	Madagascar	N. Mariana Is.	Suriname
Azerbaijan	Comoros	Haiti	Malawi	Pakistan	Swaziland
Bahamas	Congo	Herzegovina	Malaysia	Palau	Syrian A.R.
Bahrain	Congo, DR	Honduras	Maldives	Panama	Tajikistan
Bangladesh	Cote D'Ivoire	Hong Kong SAR	Mali	Papua N.G.	Tanzania UR
Belarus	Croatia	India	Marshall Is.	Paraguay	Thailand
Benin	Djibouti	Indonesia	Mauritania	Peru	Togo
Bhutan	Dominican Republic	Iran	Mauritius	Philippines	Tokelau
Bolivia	Ecuador	Kazakhstan	Micronesia	Portugal	Turkmenistan
Bosnia	El Salvador	Kenya	Moldova Rep.	Principe	Uganda
Botswana	Equ. Guinea	Kiribati	Mongolia	Romania	Ukraine
Brazil	Eritrea	Korea, DPR	Morocco	Russian Fed.	Uzbekistan
Brunei Dar.	Estonia	Korea Rep.	Mozambique	Rwanda	Vanuata
Burkina Faso	Ethiopia	Kyrgyzstan	Myanmar	Sao Tome	Vietnam
Burundi	Gabon	Lao PDR	Namibia	Senegal	Yemen
Cambodia	Georgia	Latvia	Nepal	Sierra Leone	Zambia
Cameroon	Ghana	Lesotho	N. Caledonia	Soloman Is.	Zimbabwe
Cape Verde	Guam	Liberia	Nicaragua	Somalia	
Cen. Afr. Rep.	Guatemala	Lithuania	Niger	So. Africa	

*World Health Organization. Global Tuberculosis Control. WHO Report 2002.

1. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis (TB)? YES NO
2. Were you born in one of the countries on the above list? YES NO
3. Have you lived or traveled for more than one month in any of the countries on the above list? YES NO

If you have answered YES to any of the above questions, a PPD (Mantoux) skin test is required, even if you have had BCG vaccination in the past. Test must have been performed within one year before enrollment and must be completed in the United States.

This test will be available, if necessary, at the Marquette Student Health Service after you arrive on campus. Please contact SHS by telephone (414-288-7184) for an appointment.

Health Care Provider must complete and sign below as proof of test:

TB (PPD) Skin Test	Skin Test Result (size of induration)	Chest X-Ray Required if TB skin test is positive	Health Care Provider	Treatment (if any)
Date Administered: _____	_____ mm	_____ Date of X-ray	Signature _____	
Date Test Read: _____	Signature of Health Care Provider _____	Result: NEG POS (attach copy of written report)	Address: _____ _____ _____	

Medical History

Please answer all questions. Consult your health care provider and parents for accurate, complete answers. The information is treated confidentially and will not affect your admission status.

Name: _____ MU ID#: _____ Date: _____
LAST FIRST MIDDLE

List any chronic or recurrent medical conditions or any condition that you regularly take medication for:

_____ None

List any medical problems in any of your immediate family members (parents, siblings, grandparents) for example, high blood pressure, diabetes, cancer, etc.

_____ None

List any past surgeries, serious illness, injuries or hospitalizations:

_____ None

List current medications (including oral contraceptives):

_____ None

Are you currently under a physician's care? Yes No If yes, explain:

List medication allergies or adverse drug reactions (include type of reaction):

_____ None

Name and address of current physician(s):

Insurance Data

Are you in an HMO or PPO? Yes No

Name of insurance company: _____ Group No.: _____

Cert. No.: _____ Insurance phone number to call in emergency: _____

Please obtain a copy of your medical insurance card to keep it with you.

Emergency Contact

Name: _____ Relationship to student: _____

Home telephone: (____) _____ Work telephone: (____) _____

Parental consent for care of students under age 18

The law requires that a parent/guardian grant permission for medical evaluation and/or treatment of minors (anyone under 18 years of age). The following consent must be signed by a parent/guardian of a minor so that he/she may receive medical evaluation/treatment. No major medical or surgical procedure will be performed, except in an emergency, without the parent/guardian first being contacted.

Authorization: I concur with the above and authorize, at the discretion of Student Health Service personnel, medical and surgical care including examinations, treatments, immunizations and the like for my son or daughter. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable efforts will be made to contact me, but that failure to make contact will not prevent emergency treatment necessary to help preserve life or health.

Name of parent/guardian: _____ Work telephone: (____) _____

Signature of parent/guardian: _____ Date: _____