

IMMUNIZATION RECORD (Camp Participants)

Bowling Green State University
Student Health Service
Health Center Building • Bowling Green, OH 43403-0147
Phone 419-372-2271 • Fax 419-372-8010 • www.bgsu.edu/health

REQUIRED:

Fill in dates. A non-parental health care provider must sign form. Your signature is required in sections E & F.

A. MEASLES (RUBELLA)

Must have 2 Measles immunizations or MMR injections, both AFTER FIRST BIRTHDAY AND AT LEAST 30 DAYS APART.

1. MMR

#1 ___/___/___ #2 ___/___/___
Mo. Day Yr. Mo. Day Yr.

OR

2. PRIMARY MEASLES immunization

#1 ___/___/___ #2 ___/___/___
Mo. Day Yr. Mo. Day Yr.

B. MUMPS immunization

___/___/___
Mo. Day Yr.

C. RUBELLA immunization

___/___/___
Mo. Day Yr.

D. TETANUS-DIPHTHERIA

Last tetanus-diphtheria booster

___/___/___
Mo. Day Yr.

E. Complete the MENINGITIS VACCINATION information below by checking the appropriate box.

I have had the bacterial meningitis vaccine: Menomune
 Menactra

Date received ___/___/___
Mo. Day Yr.

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided to decline vaccination at this time.

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE
If participant is under 18 years of age.

F. Complete the HEPATITIS B information below by checking the appropriate box.

I have had the hepatitis B vaccine.
#1 ___/___/___ #2 ___/___/___ #3 ___/___/___
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

I have read, or have had explained to me, the information regarding hepatitis B. I understand the risks of not receiving the vaccine and have decided to decline vaccination at this time.

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE
If participant is under 18 years of age.

RECOMMENDED:

G. POLIO

Completed primary series of Polio immunizations ___/___/___
Mo. Day Yr.

H. HEPATITIS A

#1 ___/___/___ #2 ___/___/___
Mo. Day Yr. Mo. Day Yr.

Participant's Name _____ DOB _____

I. CHICKENPOX (varicella) VACCINE

#1 ___/___/___ #2 ___/___/___
Mo. Day Yr. Mo. Day Yr.

J. TB SCREENING - REQUIRED

1. Does the participant have signs or symptoms of active TB?
 YES NO

If no, proceed to question 2.

If yes, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the participant a member of a high-risk group¹?
 YES NO

If no, STOP. No further evaluation is needed at this time.

If yes, administer tuberculin skin test (Mantoux only). A history of BCG vaccination should not preclude testing of a member of a high-risk group. If there is a history of a past positive PPD, proceed to question 4.

3. Tuberculin Skin Test (required within 1 year of enrollment if indicated by steps 1 and 2).

Date placed ___/___/___ Date read ___/___/___
Result _____ (Record actual mm of induration, transverse diameter; if no induration write "0")

Interpretation (based on mm of induration as well as risk factors):
 Positive Negative

4. Chest x-ray (required within 6 months of enrollment if tuberculin skin test is positive).

Result: Normal Abnormal Date of x-ray ___/___/___

¹Categories of high-risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. Prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

PROVIDER INFORMATION

NAME OF HEALTH CARE PROVIDER (PLEASE PRINT)

DEGREE

SIGNATURE OF PROVIDER

ADDRESS (PLEASE PRINT OR STAMP)

PHONE

FAX

FOR ADMINISTRATIVE PURPOSES ONLY

FORM COMPLETE: YES NO DATE _____
REVIEWER _____

ACTION NEEDED

DATE REQUESTED INFORMATION RECEIVED

REVIEWER