UNIVERSITY OF SAINT JOSEPH
CONNECTICUT

Masters Degree
Proof of Immunization Form

Health Services Fax: 860.231.6794

All matriculated students are required to submit proof of immunization. Students born in the U.S. before 1957 should return this form but are exempt from all immunization requirements. **Students born outside of the U.S**. must submit either Varicella (Chickenpox) titer blood test or two Varicella vaccines (date of birth and natural disease exemptions not permitted). Nursing and dietetics students are not eligible for vaccine exemptions and should use the specific "Physical Exam and Vaccine Form" instead of this form.

Name:_____ Birth date: _____ Birth place: _____

Email address: _____ Student ID: _____

Address: _____

Street Apartment/Unit Number City State Zip Country if not U.S.

Home Phone: _____ Cell Phone: _____

REQUIRED VACCINES: 2 doses MMR & Varicella vaccines (or equivalents) required for all matriculated students.

	MMR vaccine	Varicella vaccine
Dose 1		
Dose 2		

Date of varicella (chickenpox) illness _____/_____/_____

IMPORTANT FOR TITERS: Please note and attach lab report.

___ Measles ___ Mumps ___ Rubella ___ Varicella

Exemptions: U.S. born students are exempt from MMR if born before 1957 and from Varicella (chickenpox) if born before 1980. Students not born in the U.S. can only submit Varicella vaccines or titer.

Vaccine equivalents: MMR and Varicella titers acceptable. Lab reports must be attached**.** Health care provider verification of the date of natural chickenpox illness fulfills the varicella requirement. **If MMR vaccines were not given, please attach records for individual measles, mumps and rubella vaccines**; two vaccines of each MMR component must be submitted. **Boosters required for**: vaccines given before age 1, less than 28 days apart, non-immune/equivocal titers and in certain other circumstances as specified by state law.

TUBERCULOSIS TESTING
Perform testing on students who have a specific medical risk, including individuals who arrived in the U.S. from a high risk country/area of the world within past 5 years.

_____ Student does not have any symptoms or risk for tuberculosis and will not be in a health sciences program.

Test performed: PPD IGRA Date of test: _____/_____/_____ Results:_____

*IGRA testing encouraged for BCG vaccinated persons. Where applicable please **attach** IGRA and/or chest x-ray reports and treatment dates as applies.*

Phone _____ Fax_____ *** Office Stamp ***

MD/APRN/PAC name _____

Signature _____ Date _____

********** Students: Please sign and date below to acknowledge your agreement. **********

I authorize the Health Services department to take any of the specified actions to resolve incomplete items pertaining to the University health requirements. Health Services may return this form and/or the attached documents to: the email I provided, my USJ email, the mailing address provided or by fax to my health care provider using the number indicated on this form.

Student signature _____ Date _____