# Student Health Clinic

University of Northern Iowa

## University of Northern Iowa
## Immunization Record for International Students

Family Name (please print all information) first or given name middle or other name

Gender: ☐ male ☐ female Date of birth: ____/____/_____ Home country: _____
day month year

Identification Number(s): _____/_____/_____ _____
U.S. Social Security Number *(if you have one)* Your assigned University Student Identification Number *(if you have one)*

### Required Measles, Mumps, Rubella (MMR) Immunization

We recommend that you have two MMR immunizations completed in your home country, if possible at least six weeks before coming to Iowa

MMR: Proof of two MMR immunizations is a requirement for registration for classes. The only exception is for females who know or suspect they are pregnant. These individuals are exempt form this requirement until after the delivery of their child.

This requirement is fulfilled by the following documentation:

☐ Received two doses of MMR vaccine (provide both dates):

#1 ____/____/_____; (must be after your 1st birthday and **in** 1969 or later);
day month year

#2 ____/____/_____; (must be at least 28 days after #1- usually given at age 4-6 years or later)
day month year

**NOTE: Students who fail to provide required MMR documentation by the 10th day of classes will be charged $30.00 and will not be allowed to register for future classes**

### Required Tuberculosis Test

**Do not have any tuberculosis test done prior to coming to Iowa.** International students are required to have this test following their arrival to campus.

In addition:

- Do not have a chest x-ray done prior to coming to the University. **Chest x-rays (if required) must be done in Iowa.**
- If you have had INH preventive therapy or treatment for active tuberculosis, bring a copy of your treatment report written in English.

**NOTE: Students who fail to have a tuberculosis test will not be allowed to register for future classes**

### Validation

To validate this form, have it signed and dated by your physician or authorized immunization official.

_____ Date: _____/_____/_____
Signature and stamp/seal of physician or authorized immunization official day month year