

## Response Required by Sept. 2, 2009

### Mandatory Immunization Requirements for CU-Boulder Students

**Colorado State Law requires new freshman, transfer, and graduate students** to submit proof of two doses each of measles (rubeola), two rubella (German measles), and two mumps (or "MMR") vaccinations. This is a mandatory requirement for all college students born on or after January 1, 1957. Please check with your physician, high school, previous university, and/or military, to obtain an official signed or stamped copy of your records. No physical is required unless you are going to be involved in major sports.

Forms can be filled out by a physician, nurse, school health authority, or you can attach an official copy of your records to our form verifying your immunization dates. A physician or parent stating that you have had any of these diseases is **not acceptable**.

If you cannot verify your immunizations, you will need to be tested for immunity or re-immunized. Medical, religious, and personal exemptions are allowed by law. Hepatitis B and Meningitis vaccines are strongly recommended but not required.

Forms must be completed and submitted by semester deadlines to avoid a late fee and hold on your student account.

### Mandatory Immunization Forms Submission Deadline: September 2, 2009

**The following State of Colorado and university forms MUST be completed:**

- Certificate of Immunization
- Mandatory Meningococcal Disease Information
- Tuberculosis Information and Screening

**If applicable, these forms are available for download on-line:**

- Health History Form (completion recommended only if you will be using Wardenburg Health Center)
- Authorization for Treatment of a Minor (applicable if student is under the age of 18)

All forms are available for downloading on our web site: [www.colorado.edu/healthcenter/immunizations](http://www.colorado.edu/healthcenter/immunizations)

**Completed forms can be submitted in one of the following ways:**

- **MAIL:**  
University of Colorado at Boulder  
Wardenburg Health Center, 119 UCB  
Immunization Program  
Boulder, CO 80309  
*(Do not mail your records to any other department on campus.)*
- **IN PERSON:**  
University of Colorado at Boulder  
Wardenburg Health Center  
Immunization Program Office, room 333  
*(Office hours 8 – 5, Monday through Friday)*
- **FAX:** 303-492-1014

For more information call 303-492-2005 or 303-492-8214, visit the CU Immunization Program Office, room 333 in Wardenburg Health Center, or visit [www.colorado.edu/healthcenter/immunizations](http://www.colorado.edu/healthcenter/immunizations).



Colorado Department  
of Public Health  
and Environment

## CERTIFICATE OF IMMUNIZATION FOR COLLEGE STUDENTS

*Colorado law requires this form be completed and provided to the school.*

Name:	Date of Birth:
Student ID:	
Street Address:	City, State, ZIP Code:
School Name: University of Colorado at Boulder	School Address: Immunizations, 119 UCB, Boulder CO 80309
School Phone Number: 303.492.2005	School Fax Number: 303.492.1014

**Immunization requirements for Colorado college students: two doses of MEASLES, MUMPS, and RUBELLA (MMR) vaccine.**

REQUIRED VACCINE	DATE GIVEN	REQUIRED VACCINE	DATE GIVEN
MMR #1 (Measles-Mumps-Rubella)		MMR #2 (Measles-Mumps-Rubella)	

The following vaccines are strongly recommended for college students, although not required by Colorado law.

ADDITIONAL VACCINES RECOMMENDED	DATES GIVEN (IF AVAILABLE)	ADDITIONAL VACCINES RECOMMENDED	DATES GIVEN (IF AVAILABLE)
DTP/DTaP/Tdap (Diphtheria-Tetanus-Pertussis)		Varicella (Chickenpox)	
Td (Tetanus-Diphtheria)		Meningococcal	
OPV/IPV (Polio)		HPV (Human Papillomavirus)	
Hep B (Hepatitis B)		Other:	
Hep A (Hepatitis A)		Other:	

- Measles, mumps, and rubella (MMR) vaccine is not required for college students born before January 1, 1957.
- The first MMR vaccine must have been administered **no earlier than 4 days before the first birthday**. The 2<sup>nd</sup> dose of MMR vaccine or of measles vaccine must have been administered **at least 28 calendar days after the 1<sup>st</sup> dose**.
- In lieu of immunization, written evidence of laboratory tests showing immunity to measles, mumps, and rubella is acceptable. Attach written proof to the Certificate or record test results and dates in the boxes above.

**TO THE BEST OF MY KNOWLEDGE, THE PERSON NAMED ABOVE HAS RECEIVED THE IMMUNIZATIONS REQUIRED FOR SCHOOL/CHILD CARE ENTRY**

DO NOT SIGN UNLESS ALL REQUIRED IMMUNIZATIONS HAVE BEEN ADMINISTERED

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
(Physician, nurse or school health authority)

**STATEMENT OF EXEMPTION TO IMMUNIZATION LAW (DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)**

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.  
SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

**MEDICAL EXEMPTION:** The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

**EXENCIÓN POR RAZONES MÉDICAS:** El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

*Medical exemption to the following vaccine(s):*

*La exención por razones médicas aplica a la(s) siguiente(s) vacuna(s):*

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Physician (Médico)

**RELIGIOUS EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

**EXENCIÓN POR MOTIVOS RELIGIOSOS:** El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

*Religious exemption to the following vaccine(s):*

*Exención por motivos religiosos de la(s) siguiente(s) vacuna(s):*

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Parent, guardian, emancipated student or student 18 years and older  
(Padre, tutor, estudiante emancipado o estudiante de 18 años y mayor)

**PERSONAL EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

**EXENCIÓN POR CREENCIAS PERSONALES:** Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

*Personal exemption to the following vaccine(s):*

*Exención por creencias personales de la(s) siguiente(s) vacuna(s):*

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Parent, guardian, emancipated student or student 18 years and older  
(Padre, tutor, estudiante emancipado o estudiante de 18 años y mayor)

## CU-Boulder Immunization Program Mandatory Meningococcal Disease Information

On and after July 1, 2005, the state law of Colorado requires that all public and non-public post-secondary education institutions provide all incoming students (or their parents/guardians if the student is less than eighteen years of age) the following information concerning meningococcal disease.

The law also requires that all students who have not received a meningococcal vaccination (or their parents/guardians if the student is less than eighteen years of age) check a box indicating their decision on whether or not to receive a meningococcal vaccination.

- **Meningococcal disease is a serious disease** caused by a bacterium.
- **Meningococcal disease is a contagious, but largely preventable, infection of the spinal cord fluid and the fluid that surrounds the brain.** Meningococcal disease can also cause blood infections.
- About 2,600 people get meningococcal disease each year in the United States; 10 to 15 percent of these people die in spite of treatment with antibiotics. Of those who live, another 10 percent lose their arms or legs, become deaf, have problems with their nervous system, become mentally retarded, or suffer seizures or strokes.
- Anyone can get meningococcal disease, but it is most common in infants less than one year of age and in people with certain medical conditions. **Scientific evidence suggests that college students living in dormitory facilities are at a modestly increased risk of contracting meningococcal disease.**
- **Immunization against meningococcal disease decreases the risk of contracting the disease.** Meningococcal vaccine can prevent four of the five types of meningococcal disease; these include two of the three most common in the United States. Meningococcal vaccine cannot prevent all types of the disease, but it does help to protect many people who might become sick if they do not get the vaccine.
- A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of the meningococcal vaccine causing serious harm or death is extremely small. Getting a meningococcal vaccination is much safer than getting the disease.
- More information can be obtained from the Vaccine Information Statement available at <http://www.cdc.gov/nip/publications/VIS/vis-mening.pdf>. Students and their parents/guardians should discuss the risks and benefits of vaccination with their health care providers.

### Please check one box:

- I am interested in the student receiving the meningococcal vaccine. \**
- I am NOT interested in the student receiving the meningococcal vaccine.*
- The student has already received the meningococcal vaccine. \*\**

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**By my signature below, I acknowledge that I have reviewed the information provided regarding meningococcal disease.**

Please Print Name of Student: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_

Student ID / Social Security Number: \_\_\_\_\_

Signature: \_\_\_\_\_

(Parent, guardian, emancipated student, or student 18 years and older.)

Date of Signature: \_\_\_\_\_

\* To receive the meningococcal vaccination, check with your primary care provider or local health department (for a list of the local public health agencies in Colorado, go to <http://www.cdphs.state.co.us/oll/localist.html>). **Wardenburg Health Center sponsors an annual flu and meningitis vaccination clinic each fall in late October or early November.** As the clinic approaches, students are notified via e-mails and other media. Information is also mailed to the permanent address on file for each student to inform parents of the clinic.

\*\*Receipt of the meningococcal vaccine should be recorded on the Certificate of Immunization for College Students.

**CU-Boulder Immunization Program  
Tuberculosis Information and Screening Form**

Name \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_  
Last First MI

SID# \_\_\_\_\_ Where were you born? USA \_\_\_ Other Country \_\_\_\_\_  
Name of Country

*Please circle.*

1. Have you ever had a **positive** Tuberculosis Skin Test (PPD)? Yes    No
  
2. Have you ever been given **medicine(s)** to prevent or treat active Tuberculosis? Yes    No  
 If yes, which medicine did you take? \_\_\_\_\_  
 For how long? \_\_\_\_\_
  
3. Have you ever had a **BCG** (immunization for Tuberculosis)? Yes    No  
 If yes, how old were you? \_\_\_\_\_
  
4. Have you ever had **close contact** with a person with active Tuberculosis? Yes    No
  
5. Have you ever **worked or lived in** a nursing home, jail, or homeless shelter? Yes    No
  
6. Have you ever **traveled or lived in** Eastern Europe, Asia, Russia, Africa, or Latin America Yes    No  
 for more than **two months**? If so, where? \_\_\_\_\_
  
7. Have you recently had any of the following **symptoms** for no good reason? Yes    No  
 (Please circle all that apply.)  

<i>Night sweats</i>	<i>Fatigue/Tiredness</i>	<i>Fevers</i>	<i>Weight Loss</i>
<i>Poor Appetite</i>	<i>Coughing up blood</i>	<i>Cough for more than 3 weeks</i>	
  
8. Have you ever been diagnosed with a **chronic medical condition** that may Yes    No  
 impair your immune system?

*I give consent to release my Tuberculosis information to CU-Boulder Immunization Program and Wardenburg Health Center, 119 UCB, Boulder, CO 80309-0119.*

**Patient's Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Parent/guardian signature if under 18 years of age)

**If you answered "yes" to any of questions 3 – 8, you must have a Tuberculosis Skin Test (PPD).**

*The following information must be completed by a Physician's office.*

- **Tuberculin Skin Test** (Mantoux only; no tine tests):  
 Date given: \_\_\_/\_\_\_/\_\_\_      Date read: \_\_\_/\_\_\_/\_\_\_  
 Result: \_\_\_\_\_ (Record actual mm of induration, transverse diameter: if no induration, write "O")  
 Interpretation (based on mm of induration as well as risk factors): *Positive    Negative*
- **Chest x-ray** (required if tuberculin skin test is positive):  
 Result: *Normal    Abnormal*      Date of chest x-ray: \_\_\_/\_\_\_/\_\_\_

**Physician or Nurse Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number \_\_\_\_\_



**Wardenburg Health Center**

University of Colorado at Boulder  
119 UCB, Boulder, CO 80309-0119

**Authorization for Treatment of a Minor**

I, \_\_\_\_\_, being the parent or legal guardian of

\_\_\_\_\_  
*Name* *Social Security Number*

give my consent for emergency and routine medical and/or surgical treatment of this minor at Wardenburg Health Center (WHC) should his/her condition so require it per the judgment of a WHC health provider. As long as the medical and/or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow:

If there are medical/physical limitations/prohibitions, specify here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that this authorization is good until the minor mentioned above reaches his/her 18th birthday.

\_\_\_\_\_  
*Signature (Parent or Guardian)* *Date*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City* *State* *Zip Code*

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

**If this is a verbal / phone authorization:**

\_\_\_\_\_  
*Signature of WHC staff receiving authorization* *Signature of Witness to the verbal/phone authorization*