Response Required by February 5, 2014

Mandatory Immunization Requirements for CU-Boulder Students

Colorado State Law requires all new students, including, but not limited to: transfer, law, international 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 need to be filled out and signed or stamped 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 verbally stating that you have had any of these diseases is **not acceptable**.

If you cannot verify your immunizations, you can be re-immunized or be tested for immunity by a MMR titer blood test available at Wardenburg Health Center. Medical, religious, and personal exemptions are allowed by law. **Meningitis vaccines are strongly recommended but not required.**

Mandatory Immunization Forms Submission Deadline: February 5, 2014

To avoid a $25 late fee and hold on your student account, you must complete and submit your forms by the deadline.

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

1. Certificate of Immunization OR an official signed/stamped copy of your immunizations records
2. Mandatory Meningococcal Disease Information OR proof of meningococcal vaccination
3. Tuberculosis Information and Screening
4. Authorization for Treatment of a Minor (mandatory if student is under the age of 18)

All forms are also available on our web site: http://www.colorado.edu/healthcenter/forms/required-immunization-forms

Submit your completed forms in one of the following ways:

- **FAX:** 303-492-1014 (All faxed records must be legible and include student name, date of birth, and student ID)
- **EMAIL:** Scan and email your records to Immunizations@colorado.edu.
- **MAIL:** **(Do not mail your records to any other department on campus.)**
  University of Colorado at Boulder
  Wardenburg Health Center
  Patient Services Department
  119 UCB,
  Boulder, CO 80309
- **IN PERSON:** Patient Services Department, Wardenburg Health Center, room 333 (Monday – Friday, 8AM -5PM)

Please do not mail, fax or e-mail your records to any other department on campus.

For more information, please contact the CU Patient Services Office 303-492-2005, visit our office in Wardenburg Health Center, room 333, or visit our website at http://www.colorado.edu/healthcenter.

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:	School Address:
School Phone Number:	School Fax Number:

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 2nd dose of MMR vaccine or of measles vaccine must have been administered **at least 28 calendar days after the 1st 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)

Information Regarding
MENINGOCOCCAL DISEASE

For all public or nonpublic postsecondary education institutions in Colorado, the state law requires that each incoming freshman student residing in student housing, as defined by the institution, or any student who the institution requires to complete and return a standard certificate indicating immunizations received by the student as a requirement for residing in student housing, be provided with the information below. *If the student is under the age of 18 years, the student's parent or guardian must be provided with this information.*

- **Meningococcal disease is a serious disease,** caused by a bacteria.
- **Meningococcal disease is a contagious, but a 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 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 vaccine is much safer than getting the disease.
- More information can be obtained from the Vaccine Information Statement available at www.cdc.gov/vaccines/pubs/vis/default.htm. Students and their parents should discuss the risks and benefits of vaccination with their health care providers.

To receive the immunization against meningococcal disease, students should check with their own health care provider or their local health department (for a list of the local public health agencies in Colorado, go to www.cdphe.state.co.us/oll/locallist.html). The institution itself may offer the vaccine at special clinics held at the beginning of the school year or may know of other nearby locations.

Each institution must require each new student who has not received a vaccination against meningococcal disease, or, if the new student is under the age of 18 years, the student's parent or guardian, to check a box and sign (see below) to indicate that the signor has reviewed the information on meningococcal disease and has decided that the new student will not obtain a vaccination against meningococcal disease.

☐ **Please check to indicate that you have reviewed the information on meningococcal disease and have decided that the student will not obtain a vaccination against meningococcal disease.**

Date: _____

Signature (student or parent/guardian, if student is under the age of 18 years): _____

Print Name of Student: _____

Date of Birth: _____

Student ID: _____

CU-Boulder Immunization Program
Tuberculosis Information and Screening Form

Name _____ Date of Birth ___ / ___ / _____
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 **or** Blood Test (PPD,T-Spot or Quantiferon TB Gold)? Yes No
   Date (month / year)_____

2. Have you ever been given **medicine(s)** to prevent or treat active Tuberculosis? Yes No
   Date (month / year)_____
   If yes, which medicine(s) did you take? _____
   For how long? _____

3. Have you ever had a **BCG** (immunization for Tuberculosis)? Yes No
   Date(s) (month / year)_____

4. Have you ever had **close contact** with a person with active Tuberculosis? Yes No
   If yes, Date (month / year)_____

5. Have you ever **worked, volunteered or lived in** a health care facility, long term care facility, nursing home, jail/prison, or homeless shelter? Yes No

6. Have you ever **traveled or lived in** a country with significant TB risks (see low risk country list on back of page) for more than **two months?** If so, where? _____ Yes No

7. Have you recently had any of the following **symptoms** for no known reason? Yes No
   (Please circle all that apply.)
   Night sweats *Fatigue/Tiredness* *Unexplained Fevers* *Unexplained Weight Loss*
   Poor Appetite *Coughing up blood* *Productive Cough for more than 3 weeks* *Shortness of Breath*

8. Have you ever been diagnosed with a **chronic medical condition** that may impair your immune system or for which you are taking medications that suppress your immune system? Yes No
   (what condition or medication?)_____

I give consent to release my Tuberculosis Screening and Testing 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 current Tuberculosis Skin Test (PPD) or IGRA test (the latter test is preferable if you have had the BCG vaccine). If you have had a prior positive TB skin or blood test and have not undergone treatment for latent or active TB disease, you must have a recent chest x-ray.

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

• (circle which test you have done)

Tuberculin Skin Test (Mantoux only; no tine tests) or **T-Spot** or **Quantiferon TB Gold blood test**:
Date Skin test placed: ___/___/___ Date read: ___/___/___ Result of skin test: _____mm
(Record actual mm of induration for TB skin test: if no induration, write "O")

Result of TB-specific blood test (actual value of test result, do not indicate negative or positive): _____ (IU/ml or #spots)

• **Chest x-ray** (required if tuberculin skin test is positive):
Result: *Normal* *Abnormal* Date of chest x-ray: ___/___/___

Physician/PA/NP/Public Health Signature: _____ Date _____
Address: _____
Telephone Number: _____ Fax Number_____

Wardenburg Health Center
UNIVERSITY OF COLORADO **BOULDER**

119 UCB, Boulder, CO 80309-0119

Authorization for Treatment of a Minor

I, _____, being the parent or legal guardian of

_____ _____ _____,
Print Name of Student *Student's Date of Birth* *Student ID 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 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*