

**OGLETHORPE UNIVERSITY  
CERTIFICATE OF IMMUNIZATION**

PLEASE PRINT

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle  
 Student Datatel ID No.: \_\_\_\_\_ (will be assigned) Gender:  Male  Female

**Meningococcal Disease Information Acknowledgement**

Meningococcal disease is a serious disease that can lead to death within only a few hours of onset; one in ten cases is fatal; and one in seven survivors of the disease is left with a severe disability, such as the loss of a limb, mental retardation, paralysis, deafness, or seizures. Meningococcal disease is contagious but a largely preventable infection of the spinal cord fluid and the fluid that surrounds the brain; scientific evidence suggests that college students living in dormitory facilities are at a moderately increased risk of contracting meningococcal disease; and Immunization against meningococcal disease will decrease the risk of the disease. All Students who are 18 years of age or older are **required to sign** this documented stating that he or she has received a vaccination against meningococcal disease **or** has reviewed the above information provided. If a student is a minor, only a parent or guardian may sign such document. **This portion MUST BE SIGNED when returned to Health Services or dorm room assignment and/or class registration will be delayed.** Vaccination updates can be made by OU Nurse when documentation is provided to Health Services.

Waiver: I have read the above information concerning meningitis and have elected to do the following:

I have elected not to be immunized at this time.  As documented in *Section III*, I have had the Meningitis Vaccination

Student's Signature (or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROFESSIONAL**  
 Mandatory Immunizations – Must indicate MO/DAY/YR – All information must be in English.

**Section I: 2 Vaccinations Are Required or Laboratory /Serology Evidence of Immunity Attached.**

\*MMR #1: \_\_\_\_/\_\_\_\_/\_\_\_\_ **OR** \*Measles #1: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*#2: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \*MMR #2: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Mumps: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \*Rubella: \_\_\_\_/\_\_\_\_/\_\_\_\_

\* Not required if born before 1957.

**Section II: Required.** Tuberculosis screening can be scheduled through OU Health Services during orientation for a fee. **Tuberculosis Screening (PPD required regardless of prior BCG inoculation) Tine or Monovac not acceptable.**

PPD (Mantoux) within the past 12 months (in mm):  Positive: \_\_\_\_  Negative: \_\_\_\_ Date: \_\_\_\_\_

If PPD is positive, documentation of chest x-ray results:  Normal  Abnormal Date: \_\_\_\_\_

Documentation of Treatment: \_\_\_\_\_

**Tetanus Booster:** Must have had booster within last ten years. \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hepatitis B series:** #1: \_\_\_\_/\_\_\_\_/\_\_\_\_ #2: \_\_\_\_/\_\_\_\_/\_\_\_\_ #3: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\* required of pre-med. students and those students who are 18 years of age or younger @ time of expected admission.

History of **Chicken Pox:**  Yes: \_\_\_\_ (Mo/YR)  No - Varicella Immunization: **2 doses required after age 13** #1: \_\_\_\_ #2: \_\_\_\_

Varicella antibody titer for (chicken pox)  Reactive: \_\_\_\_\_  Non-reactive: \_\_\_\_\_

**Section III: Strongly Recommended.** The Health Center will offer vaccination clinics by the Board of Health during the semester.

Meningitis Vaccination: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hepatitis A series: #1: \_\_\_\_/\_\_\_\_/\_\_\_\_ #2: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Advised if considering Study Abroad Program

HPV #1 \_\_\_\_ #2 \_\_\_\_ #3 \_\_\_\_ Other Travel Vaccinations: \_\_\_\_\_

**Section IV:**

Exemption from mandatory immunization policy is requested based upon the following reason:

- Religious:** Requires a notarized statement, preferably from religious leader. Students declaring religious exemption will be automatically withdrawn if a case of measles, mumps, or rubella occurs on campus.
- Medical:** Your physician must provide in writing the *reason* for medical exemption from immunization requirements and whether it is temporary or permanent.

**Immunization status indicated above is certified by:**

Signature of physician or health facility official

Date

Address of physician or health facility official

Stamp

Phone

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_



Student Health Services  
4484 Peachtree Road  
Atlanta, Georgia 30319

# OGLETHORPE

UNIVERSITY

Office (404) 364-8413  
Fax (404) 364-8442

## IMMUNIZATION AND HEALTH HISTORY FORM

Congratulations on your acceptance to Oglethorpe University! Oglethorpe University Student Health Services require all applicants to satisfy immunization requirements for measles, mumps, and rubella (MMR), Hepatitis B, Tetanus Booster, Varicella (Chicken Pox) and Tuberculosis Screening before being eligible for final admissions consideration. At this time we are **STRONGLY RECOMMENDING** students living in residence halls, particularly freshmen, receive the Meningococcal vaccine. Please refer all questions regarding immunizations to **Cathy Grote, R.N.** Director of Health Services at (404) 364-8413 or to the Office of Student Affairs at (404) 364-8423. **Mail or fax this form to Student Health Services at the above address at least three (3) weeks prior to beginning of classes.** Failure to complete this form will delay class registration.

### GENERAL INFORMATION: PLEASE PRINT.

Name: \_\_\_\_\_ SS No.: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
Street Address City State Zip

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_ Admission for Fall/Spring/ Summer:200\_\_\_\_\_

If Commuter:

Local Address: \_\_\_\_\_ Local Phone Number: \_\_\_\_\_  
Street Address City State Zip

Please check:  Freshman  Sophomore  Junior  Senior  Transfer Student from \_\_\_\_\_

Housing, please check: Commuter StudentBoard on CampusGA Rotary StudentInternational Student From \_\_\_\_\_

**HEALTH INFORMATION:** A brief health history form is included. All health information is confidential and will be utilized only in matters concerning your health

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you have any significant, on-going health problems or concerns of which you want the Health Center to be aware?  No

Yes: \_\_\_\_\_

Are you currently taking any prescription medications?  No  Yes, please list: \_\_\_\_\_

Do you have any allergies to food, medicine, etc.?  No

Yes please describe reactions: \_\_\_\_\_

Will you be participating in intercollegiate sports?  No  Yes Sport: \_\_\_\_\_

Physical for Sports Completed?  No  Yes  Attached

Name of Private Health Insurance carrier for student \_\_\_\_\_

### PERSONS TO NOTIFY IN AN EMERGENCY:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Office Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Office Phone: \_\_\_\_\_

For the protection of the student in unforeseen situations (accident or emergency surgery, the University needs a signed release to facilitate emergency care required by the student while in attendance at Oglethorpe University.

### Permission for Diagnostic & Treatment Procedures:

*I hereby authorize the Physicians/Nurse of the Oglethorpe University Student Health Center, their agents or consultants to evaluate and perform diagnostic and treatment procedures which in their judgment may become necessary on the student named below while he or she is a student at Oglethorpe University. I waive all claims to prior notification.*

Signature of Student: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian (if student under 18): \_\_\_\_\_

Date: \_\_\_\_\_

*Oglethorpe University Student Health Services is looking forward to serving you.*