Student Health Services
Laurel Hall
282 The Green
Newark, DE 19716-8101
Phone: 302-831-2226
Fax: 302-831-6407

ELI Immunization Documentation

Not to be used for Academic Transition (AT) students

All of the following information **must be completed and signed by your health care practitioner**.

Additional information regarding required immunizations, TB screening, meningitis disease and vaccination, and exemptions can be found on the Student Wellbeing Required Forms (udel.edu/students/health-wellbeing/records-and-billing/required forms) page.

Must be completed in English. All dates in Western/Gregorian calendar.

Student Name: _____
Family Name First Middle

Date of Birth: _____ UDID #: _____
Month Day Year

Country of Birth: _____ If **not** USA, indicate when you entered this country: _____
MM/YYYY

Parental/Guardian Permit (For students under age 18): I give my permission for medical care and procedures as may be deemed necessary for my student and agree to present information concerning his/her medical condition to other responsible University officials when deemed necessary. I give permission to bill for any medical care performed.

Signed: _____ Relationship: _____

If this form is not complete, you will not be permitted to register for the next session.

1. Required – All students born after 1957

MMR (Measles, Mumps, Rubella) – Two doses required after 12 months of age and at least 28 days apart.

MMR Dates: MMR dose one: _____ MMR dose two: _____
MM/DD/YY MM/DD/YY

OR

Measles Vaccine Date: _____ or **Antibody Titer Date*:** _____
MM/DD/YY MM/DD/YY

Mumps Vaccine Date: _____ or **Antibody Titer Date*:** _____
MM/DD/YY MM/DD/YY

Rubella Vaccine Date: _____ or **Antibody Titer Date*:** _____
MM/DD/YY MM/DD/YY

*Must enclose copy of lab report

See reverse side of form for additional immunization history, religious/medical exemption and practitioner's signature.

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2. Required Tuberculosis Screening Questionnaire – All students

2A – Tuberculosis (TB) Risk Questionnaire

1. Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No
2. Were you born in a country listed below? ☐ Yes ☐ No
3. Have you resided in or traveled in one or more of the countries or territories listed below for a period of one to three months or more? ☐ Yes ☐ No
4. Have you been a resident, volunteer and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities and homeless shelters)? ☐ Yes ☐ No
5. Have you been a volunteer or health care worker who serve clients who are at increased risk for active TB disease? ☐ Yes ☐ No
6. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease (i.e., medically underserved, low-income, or using drugs or alcohol)? ☐ Yes ☐ No

Afghanistan, Algeria, Angola, Argentina, Armenia, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, (Plurinational State of) Bosnia and Herzegovina, Botswana, Brazil, Brunei, Derussalam, Burkina Faso, Burundi, Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, China - Hong Kong Special Administrative Region, China - Macao Special Administrative Region, Colombia, Comoros, Congo, Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Fiji, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Liberia, Libya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mexico, Micronesia, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, São Tomé and Principe, Senegal, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Tajikistan, Thailand, Timor-Leste, Togo, Tunisia, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela, (Bolivarian Republic of) Viet Nam, Yemen, Zambia, Zimbabwe

2B –

If you answer NO to all the above questions, no further action is required. If you answer YES to any of the above questions, you are required to have a TB Blood Test (IGRA), **within 6 months prior to beginning of session**. Prior BCG does not exempt students from this requirement. If your TB Blood Test is positive, please attach chest x-ray results that were completed in the USA. All TB testing must be the same day or 28 days after any live vaccines.

2C – TB Blood Test*

QuantiFERON: _____ MM/DD/YY

OR

T-Spot: _____ MM/DD/YY

Result: ☐ Negative ☐ Positive

*Enclose copy of USA X-ray report

2D – Chest X-Ray*

Date: _____ MM/DD/YY

Result: ☐ Negative ☐ Positive

*Enclose copy of USA X-ray report

2E – Medication Treatment for TB

Drug: _____

Dose and Frequency: _____

Treatment Start Date: _____ MM/DD/YY

Treatment End Date: _____ MM/DD/YY

A physical examination is not required. • All information must be in English. • Please Print.

Health Care Practitioner Signature (Physician, Nurse Practitioner, P.A., Nurse)

Name: _____ Address: _____

Signature: _____ Date: _____ Phone: _____

Immunization Exemptions: A signed letter is required for religious exemptions. A healthcare practitioner's signed letter is required for medical exemptions.

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Personal Information and Health History

Please include the following information to best serve you. **Must complete this form.**

Full Legal Name: _____ **Preferred Name:** _____
Surname/Family Name First

Date of Birth: _____ **Date Completing Form:** _____
MM/DD/YY MM/DD/YY

Phone Number in United States: _____

Emergency Contact: Names of two individuals to contact in case of an emergency.

Name	Relationship	Phone Number

Allergies – medication, food or materials (e.g., latex)

☐ Check if no known drug allergies/sensitivities, latex allergy, food allergy

Food/Medication/Substance	Type of Reaction	Approx. Date of Onset

Current Medications – taken on a regular basis (e.g., insulin, birth control pills, seizure or heart medicine)

☐ Check if no medications currently taken

Name of Medication	Dosage of Medication	Start Date

Hospital Admissions and Surgeries (please list ALL)

Description	Approx. Date(s)

Current (or past) Medical History (e.g., asthma, diabetes, heart conditions, thyroid, seizure disorder)

Description	Approx. Date(s)

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Family History of Illnesses – Please list if there is a family (e.g., grandparents, siblings) history of illness such as diabetes, high blood pressure, sudden/unexplained deaths, etc.)

Do you smoke/vape? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If you answer "Yes," how often do you smoke and/or drink alcohol?

Please provide additional information for allergies, medications or hospital admissions or surgery information in the space below, if necessary.