

Please circle if you are: an International Student, and/or living in the Residence Hall

NORTH IDAHO COLLEGE IMMUNIZATION RECORD

Please Print Legibly

Name _____
Last Name First Name Middle Name Phone Number

Permanent Address _____
Street City State Zip Code Country

Today's Date _____ Date of Birth ___/___/___ Student ID Number or last 4 digits of Social Security _____

To Be Completed and Signed By Your Health Care Provider or please attach official immunization record.

All Information must be in English.

Required for, international students, and/or Residence Hall living

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)

1. Dose 1 given at age 12-15 months or later.....#1 ___/___
M Y

2. Dose 2 given at 4-6 years or later, and at least one month after first dose.....#2 ___/___
M Y

B. HEPATITIS B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)

1. Immunization

a. Dose #1 ___/___ b. Dose #2 ___/___ c. Dose #3 ___/___ or
M Y M Y M Y

2. Hepatitis B surface antibody (titer should only be drawn after vaccine series or exposure)
Date ___/___ Result Reactive _____ Non-reactive _____
M Y

Additional International Student Requirement

C. POLIO (Primary series in childhood meets requirement; 1 of the three primary series schedules are acceptable.)

1. OPV alone (oral Sabin three doses):#1 ___/___ #2 ___/___ #3 ___/___
M Y M Y M Y

2. IPV alone (injected Salk four doses).....#1 ___/___ #2 ___/___ #3 ___/___ #4 ___/___
M Y M Y M Y M Y

3. IPV/OPV sequential.....IPV #1 ___/___ IPV #2 ___/___ OPV #3 ___/___ OPV #4 ___/___
M Y M Y M Y M Y

D. Tuberculosis Skin Test:

(Example: PPD, tine)

If positive PPD, when was your Chest X-ray?

Date: ___/___/___ Result: _____
(Must be within 1 year of entry into U.S.)

Date: ___/___/___ Result: _____
(Must be within 1 year of entry into U.S.)

INTERNATIONAL STUDENT HEALTH CARE PROVIDER VERIFICATION STATEMENT:

I certify that I have medically examined the above-named person. I have found him/her to have no physical or psychological condition which interferes with his/her taking a full course of study at North Idaho College.

Name _____ Signature _____

Additional Recommended Vaccinations

E. Meningococcal (One dose---preferably at entry into college for freshmen living in residence halls who wish to reduce their risk of meningococcal disease.)

Quadrivalent polysaccharide vaccine.....Date ___/___/___
M D Y

F. Tetanus-Diphtheria (Primary series with DTaP or DTP and booster with Td in the last ten years meets requirement.)

1. Primary series of four doses with DtaP or DTP:

#1 ___/___ #2 ___/___ #3 ___/___ #4 ___/___
M Y M Y M Y M Y

2. Tetanus-Diphtheria (Td) booster within the last ten years ___/___
M Y

Health Care Provider Statement: I have verified this patient's immunization record and/or given the needed vaccines.

Name _____ Signature _____

Address _____

Phone _____ Fax _____

Please return form to:

North Idaho College, Student Health Services, 1000 West Garden Avenue, Coeur d'Alene, Idaho 83814
Telephone Number: 208.769.7818 Fax Number: 208.665.5438