AMERICAN UNIVERSITY
WASHINGTON, DC

Student Health Center
2014-2015 Mandatory Immunization Information

The District of Columbia Immunization Law requires that ***all students, under age 26 and no matter how many credit hours they are enrolled in,*** provide proof of the immunizations listed on the AU Mandatory Immunization Form.

If you have received immunizations that do not fall into the immunization schedule (for instance receiving an immunization a week early) you will need to provide titer results showing immunity.

REQUEST FOR MEDICAL OR RELIGIOUS EXEMPTION

Religious exemption is allowed if the responsible person objects in good faith and in writing that the immunizations violate his/her religious beliefs. The letter should be addressed to the President of American University as the head of the institution.

Medical exemption is allowed if a physician provides a detailed letter indicating that immunizations are medically inadvisable.

SUBMISSION DEADLINES

Washington DC law mandates that no student shall be admitted by a school unless the school has certification of immunization for that student. All required students must have their completed AU Mandatory Immunization Form submitted to the Student Health Center by August 1, 2014 for fall admission and January 1, 2015 for spring admission.

SUBMITTING THE MANDATORY IMMUNIZATION FORM

Please follow the instructions online at **http://www.american.edu/ocl/healthcenter/Immunization-FAQs.cfm** to enter your immunizations online.

Once you have completed entering all of the required immunizations, please keep a copy of the attached form for your records, and submit the AU Mandatory Immunization Form via one of the methods listed below.

- The completed/signed/stamped form can be submitted via an email attachment to **immunizations@american.edu**.
- The completed/signed/stamped form can be faxed to **(202) 885-1222**.
- The completed/signed/stamped form can be mailed to the following address:

American University
Student Health Center
4400 Massachusetts Avenue, NW
McCabe Hall
Washington, DC 20016-8036

The University does not require physicals as a prematriculation requirement.

AMERICAN UNIVERSITY
2014-2015 MANDATORY IMMUNIZATION FORM

All dates should be recorded in the mm/dd/yyyy format. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid.

To be completed by the American University Student.	
Last Name First Name Initial	**AUID Number**
Date of Birth (MM/DD/YYYY)	**Home Phone Number**
Email Address	**Semester and Year of Entry**

To be completed by the medical provider.

Tetanus/Diphtheria _____/_____/_____ (Given in the last 10 years.)
-or-
Tetanus/Diphtheria/Pertussis_____/_____/_____ (Given in the last 10 years.)

MMR #1 ____/____/_____ (Given after 1 year of age) **MMR#2** ____/____/_____ (Given at least 30 days after Dose 1)
-or-
Measles #1 ____/____/_____ Measles#2 ____/____/_____

Mumps #1____/____/_____ Mumps #2 ____/____/_____

Rubella #1____/____/_____ Rubella #2 ____/____/_____
-or-
Immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.

Hepatitis B #1 ____/____/___ **Hepatitis B #2** ____/____/_____ (Given at least 4 weeks after Dose 1)

Hepatitis B #3 ____/____/___ (Given at least 16 weeks after Dose 1 and 8 weeks after Dose 2)
-or-
Immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.

Varicella #1 ____/____/_____ **Varicella #2** ____/____/_____ (Given at least 30 days after Dose 1)
-or-
History of Disease ____/_____ (month/year)
-or-
Immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.

For students living on campus or in university sponsored housing:
Meningococcal ____/____/_____ _____Menactra _____Menomune
-or-
Attached Meningitis Waiver. Can also be found on the Forms section of the Student Health Center Web site.

Additional Requirement for Students 17 and under:
Polio#1 ____/____/_____ **Polio #2** ____/____/_____ **Polio #3** ____/____/_____
-or-
Attached lab report showing positive immunity

_____

Healthcare Provider Signature/Title **Date**

OFFICE STAMP of SIGNING CLINICIAN

An Office stamp must be used to validate this form

For AU SHC Office Use Only: Entered By: Student Staff Initials:_____Compliant Verified

Noncompliant: TD/TDap MMR HepB Varicella Meningococcal Polio

American University
Student Health Center
Information about Meningococcal Disease and Vaccination and
Waiver Form for First Year Students and Students Who Reside in University Housing

District of Columbia municipal regulations mandate each first-year student enrolled in a school of post-secondary education in the District of Columbia and living, or who may live, in on-campus student housing to receive one (1) dose of meningococcal vaccine.

The regulation provides an **exemption** for students signing a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this **exemption** you are required to review the information below and sign the waiver at the end of this document. Please note if a student is under 18 years of age, a parent or legal guardian must be given a copy of this document and must sign the waiver.

Meningococcal Disease Facts

- Meningococcal disease is a serious infection caused by bacteria, most commonly causing meningitis (an infection of the membranes that surround the spinal cord and brain) or sepsis (an infection of blood that affects many organ systems).

- College freshmen, particularly those living in residence halls, have a modestly increased risk of getting the disease compared with other persons the same age. Up to 100 cases occur among the 15 million college students in the United States each year, with 5-15 deaths. However, the overall risk of disease, even among college students, is low.

- Crowded living conditions and smoking (active or passive) are additional risk factors that are potentially modifiable.

- Bacteria are spread from person-to-person through secretions from the mouth and nose, transmitted through close contact. Casual contact or breathing in the same air space is not considered sufficient for transmission.

- Common symptoms include: stiff neck, headache, fever, sensitivity to light, sleepiness, confusion, and seizures.

- The disease can be treated with antibiotics, but treatment must be started early. Even with treatment, some patients may die. Survivors may be left with a severe disability such as the loss of a limb.

- There is a vaccine available that can protect you from 4 of the 5 most common types of meningococcal bacteria. The vaccine lasts for 3-5 years. Vaccination may decrease the risk of meningococcal disease; however it does not eliminate the risk because the vaccine does not prevent against all types of meningococcal bacteria. Approximately 50-70% of disease among college students is likely to be vaccine-preventable.

- The vaccine is available through private providers, travel clinics, health departments, and the Student Health Center at American University.

Students may begin classes without a certificate of immunization against meningococcal disease if: 1) the student has a letter from a physician stating that there is a medical reason why he/she can't receive the vaccine; 2) the student (or the student's parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or 3) the student (or the student's parent or legal guardian, if the student is a minor) signs the waiver below stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and: a) elected to decline the vaccine; or b) could not obtain meningococcal vaccine due to a shortage, but wishes to receive vaccine (as indicated below).

Waiver for Meningococcal Vaccination Requirement

By signing below, I state that:
I am either eighteen (18) years of age or older and applying for this waiver on my own behalf; or I am the parent or legal guardian of the student identified below and applying for this waiver on his/her behalf.

I have received and reviewed the information provided by American University on the risks of contracting meningococcal disease and the availability and effectiveness of meningococcal vaccine.

I understand that District of Columbia law requires newly enrolled students at colleges and universities who are living in residence halls to receive meningococcal vaccinations, unless the students provide a signed waiver of the vaccination or otherwise qualify for one of the exemptions specified in the law.

After reviewing the materials identified above, I have voluntarily decided to refuse the meningococcal vaccine on my own behalf or on the behalf of the student identified below if his/her is less than eighteen (18) years of age.

I understand that if I reconsider my decision, I may return to the Student Health Center to receive the vaccine.

I hereby release American University, its employees from all responsible for any consequences of my decision.

Student Name:_____Date of Birth:_____

Student ID:_____

Student Signature:_____Date:_____
If Student is under the age of eighteen (18), signature of parent or legal guardian:

_____ _____ _____
Parent or Legal Guardian's Signature Printed Name Date

RECOMMENDED: TUBERCULOSIS SCREENING
Have you ever had a positive TB skin test? ☐ Yes ☐ No
Have you ever had close contact with anyone who was sick with TB? ☐ Yes ☐ No
Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years?(If yes, please CIRCLE the country)☐Yes ☐No
Have you ever traveled to/in one or more of the countries listed below? (If yes, please CHECK the country/ies) ☐ Yes ☐ No
Have you ever been vaccinated with BCG? ☐ Yes ☐ No
If you answered yes to any of the Tuberculosis screening questions, American University recommends that you have a Tuberculin Skin Test (TST) at the Student Health Center when you arrive on campus.

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Congo DR
Cote d'Ivoire
Croatia
Djibouti
Dominican Republic
Ecuador
Egypt
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Fr. Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Korea-DPR
Korea-Republic
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Lithuania
Macedonia-TFYR
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
Moldova-Rep.
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
N. Mariana Isl
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
St. Vincent & The Grenadines
Sao Tome & Principe
Saudi Arabia
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Spain
Sri Lanka
Sudan
Suriname
Syrian Arab Republic
Swaziland
Tajikistan
Tanzania-UR
Thailand
Timor-Leste
Togo
Tokelau
Tonga
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Wallis & Futuna Isl
W. Bank & Gaza Strip
Yemen
Zambia
Zimbabwe

American University

Student Health Center

Consent to Treat Minor Patients

District of Columbia law requires consent of a parent / legal guardian for medical care of minors. If your son or daughter is enrolled at American University prior to his / her eighteenth birthday and they seek care at the Student Health Center, you must complete and return the following consent to:

Student Health Center
American University
4400 Massachusetts Avenue, NW
Washington, DC 20016-8036

Consent for Medical Treatment

I, _____ (print name here), am the parent/legal guardian of

_____(print name of student), currently a minor, whose date of birth is ___/_____/_____.

I authorize the American University Student Health Center to provide medical care to my son/daughter, including, but not limited to diagnostic examinations (including laboratory testing), tuberculosis screening, verification and/or administration of immunizations and necessary medical treatment.

I understand that once my child reaches the age of majority, my consent for treatment is no longer required.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions I had prior to signing could be answered by calling the Student Health Center at 202.885.3380.

_____ _____

Signature Date

Emergency Phone: Home ( ) _____ Work ( )_____

Cell ( )_____