Student Health Center
2009-2010 Mandatory Immunization Information

The District of Columbia Immunization Law requires that all students, under age 26 (except for students who meet statutory requirements for exemption based upon religious or medical reason) provide proof of the following immunizations prior to registration:

1. One Tetanus and Diphtheria booster given within the past ten years. (Tdap is recommended.)
2. Two vaccinations against Measles, Mumps, and Rubella (MMR), given after age one and at least 30 days apart.
3. Two vaccinations against Varicella (Chickenpox) given at least 30 days apart, or a history of Chickenpox verified by titer results. DC requires two doses of the Varicella vaccine regardless of the age the student was first vaccinated.
4. Three vaccinations against Hepatitis B, dose 2 given thirty days after dose 1, dose 3 given four months after dose 2.
5. Any first year student living in university sponsored housing must be immunized against Meningitis or sign a waiver stating they have read and understand the risks of the disease and do not wish to be immunized. Important information regarding Meningitis can be found on the back of this document.
6. Any student under the age of 18 must show proof of being vaccinated against Polio.

If you have received immunizations that do not fall into the immunization schedule above (for instance receiving an immunization a week early or a month late) 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 or ethical beliefs. Medical exemption is allowed if a physician or health care provider deems an immunization medically inadvisable. Students who wish to be exempt due to religious or medical reasons must submit this form as well as a letter from a medical provider or religious clergy which states the need for exemption.

DEADLINES: The deadline for fall submission is August 1, 2009. The deadline for spring submission is January 1, 2010.

Please obtain any needed immunizations, complete this form with your medical provider (keep a copy for your records) and mail the original to the Student Health Center at the following address:

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

The Student Health Center WILL NOT accept copies of immunization forms. The Mandatory Immunization Form is the only form that will be accepted as proof of vaccination.

If you have any questions, please contact the Student Health Center at 202.885.3380.

Incomplete information or invalid dates on this form will prevent you from registering for future semesters and a STOP will be placed on your account. Students not in compliance with this requirement may not be allowed to attend classes.

The University does not require physicals as a prematriculation requirement.
American University
Student Health Center
Information about Meningococcal Disease and Vaccination and
Waiver for 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).
American University  
Student Health Center  
Waiver for Meningococcal Vaccination Requirement

By signing below, I state that:

1. 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.

2. 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.

3. 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.

4. 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.

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

6. 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       Date  

___________________________________
Print Name
All dates should be recorded in the mm/dd/yyyy format. Please complete the front and back of this form and have the form signed and stamped by your medical provider.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Initial</th>
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**Date of Birth (MM/DD/YYYY)**

**Email Address**

**Home Phone Number**

**Semester and Year of Entry**

**Tetanus/Diphtheria** 

- or -

**Tetanus/Diphtheria/Pertussis**

**MMR #1**

- or -

**MMR #2**

**MMR #3**

**Measles #1**

- or -

**Measles #2**

**Mumps #1**

- or -

**Mumps #2**

**Rubella #1**

- or -

**Rubella #2**

**Hepatitis B #1**

- or -

**Hepatitis B #2**

**Hepatitis B #3**

**Varicella #1**

- or -

**Varicella #2**

**Varicella #3**

For students living on campus or in university sponsored housing:

**Meningococcal**

- or -

**Menactra**

**Menomune**

For students 17 and under:

**Polio #1**

- or -

**Polio #2**

**Polio #3**

**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

Afghanistan  Cambodia  Fr. Polynesia  Kuwait  Mozambique  Russian Federation  Thailand

Algeria  Cameroon  Gabon  Kyrgyzstan  Myanmar  Rwanda  Timor-Leste

Angola  Cape Verde  Gambia  Lao PDR  Namibia  St. Vincent & Togo


Argentina  Chad  Ghana  Lesotho  Nepal  Sao Tome & Principe  Tonga

Armenia  China  Guam  Liberia  New Caledonia  Saudi Arabia  Tunisia

Azerbaijan  Colombia  Guatemala  Lithuania  Nicaragua  Senegal  Turkey

Bahamas  Comoros  Guinea  Macedonia-TFYR  Niger  Seychelles  Turkmenistan

Bahrain  Congo  Guinea-Bissau  Madagascar  Nigeria  Sierra Leone  Tuvalu

Bangladesh  Congo DR  Guyana  Malawi  Niue  Singapore  Uganda

Belarus  Cote d'Ivoire  Haiti  Malaysia  N. Mariana Isl  Solomon Islands  Ukraine

Belize  Croatia  Honduras  Maldives  Pakistan  Somalia  Uruguay

Benin  Djibouti  India  Mali  Palau  South Africa  Uzbekistan

Bhutan  Dominican Republic  Indonesia  Marshall Islands  Panama  Spain  Vanuatu

Bolivia  Ecuador  Iran  Mauritania  Papua New Guinea  Sri Lanka  Venezuela

Bosnia & Herzegovina  Egypt  Iraq  Mauritius  Paraguay  Sudan  Viet Nam

Botswana  El Salvador  Japan  Mexico  Peru  Suriname  Wallis & Futuna Isl

Brazil  Equatorial Guinea  Kazakhstan  Micronesia  Philippines  Syrian Arab Republic  W. Bank & Gaza

Brunei Darussalam  Eritrea  Kenya  Moldova-Rep.  Poland  Swaziland  Strip

Bulgaria  Estonia  Kiribati  Mongolia  Portugal  Tajikistan  Yemen

Burkina Faso  Ethiopia  Korea-DPR  Montenegro  Qatar  Tanzania-UR  Zambia

Burundi  Fiji  Korea-Republic  Morocco  Romania  Zimbabwe
TUBERCULOSIS SCREENING (CONTINUED)
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.

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 section:

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 of Parent or Guardian                  Date                           Phone Number

__________________________________________  ____________________________
Healthcare Provider Signature/Title/Phone Number  Date

An Office stamp must be used to validate this form

For Office Use Only: Entered By:________________________ Compliant
Noncompliant with   TD    HepB   Varicella   MMR   Polio   Meningitis