



AMERICAN UNIVERSITY  
WASHINGTON, DC

**Student Health Center  
2010-2011 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 in this packet.
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 September 1, 2010. The deadline for spring submission is January 3, 2011.

Please obtain any needed immunizations, complete this form with your medical provider (*keep a copy for your records*) and follow the instructions below to electronically enter your immunization record. **PLEASE NOTE YOU WILL ONLY BE ABLE TO ENTER IMMUNIZATION INFORMATION AFTER YOU HAVE REGISTERED FOR CLASSES.**

1. Go the Student Health Center Web site ([www.american.edu/healthcenter](http://www.american.edu/healthcenter))
2. Find the yellow "Schedule Your On-line Appointment or Enter Your Immunization Information" Link
3. Click on Register. You will be asked to read and agree to the Terms of Use and check that you understand that the on-line system is not monitored 24 hours a day and is not to be used for emergencies. After you read and agree to both statements you will click next to continue.
4. Enter your 7 digit AUID and birth date and click next to continue. (Please remember you will not be able to register for the system until you have registered for classes).
5. Create a user ID and password that is between 6-12 characters long. You cannot use special character. Click "Next" to continue.
6. Update and verify your campus address, permanent address, and emergency contact information. Click Update to verify all information is accurate. If you find any discrepancies, go Back to make corrections.
7. Click on Immunization Records (Please note your status will show that you are Not Compliant until you submit the necessary documentation to prove your immunizations to the Student Health Center.)
8. To add a new immunization select "Add New". You will enter immunizations for Hepatitis B Dose 1, Hepatitis B Dose 2, Hepatitis B Dose 3, MMR Dose 1, MMR Dose 2, Varicella 1, Varicella 2 (or titer results proving immunity) and Tetanus (or Tdap) and Meningitis.

9. Select the immunization you wish to enter from the drop down list.
10. Enter the month, day, and year when you received the immunization.
11. For result, select “No Result Required.”
12. Indicate whether the immunization was received within or outside the United States.
13. When you have finished entering the details of the immunization, click “Enter”.

If you do not have the dates that you have been immunized, but have titer results proving your immunity you will follow the same steps as above, except you will select the titer that corresponds with the immunization. For result, you will select “Positive.”

**IF YOU HAVE NOT RECEIVED THE VACCINATION FOR VARICELLA, BUT HAD THE DISEASE YOU WILL BE REQUIRED TO SUBMIT TITER RESULTS.**

If you have not received the Meningitis vaccination and wish to submit a waiver stating that you know the risks associated with the disease, please complete the Waiver for Meningococcal Vaccination (included in this packet) and enter the following on-line:

1. Select “Add New”.
2. Click on the bubble marked “Waiver”
3. Select Meningococcal from the Immunization Drop Box
4. Select “Signed Waiver” from the Waiver Drop Box.
5. Select “No” from the Has Expiration Drop Down Box.
6. Click on “Add”

Once you have completed entering all of the required immunizations, please keep a copy of the attached form for your records, and mail the completed form to the address below. **Please do not fax the records as they often become illegible during fax transmission.**

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, invalid dates, or the lack of a signature from your medical provider will prevent you from being compliant and a **STOP** will be placed on your account which may prevent you from registering for future semesters. 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

**AMERICAN UNIVERSITY  
STUDENT HEALTH CENTER  
2010-2011 MANDATORY IMMUNIZATION FORM**

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.

<b>Last Name</b>	<b>First Name</b>	<b>Initial</b>	<b>AUID Number</b>
<b>Date of Birth (MM/DD/YYYY)</b>			<b>Home Phone Number</b>
<b>Email Address</b>			<b>Semester and Year of Entry</b>
<b>Tetanus/Diphtheria</b> ____/____/____ (Booster in the last 10 years. Tdap recommended) -or- <b>Tetanus/Diphtheria/Pertussis</b> ____/____/____			
<b>MMR #1</b> ____/____/____ (1 <sup>st</sup> dose must be after 12 months of age) <b>MMR#2</b> ____/____/____ (Given at least 30 days after dose 1) -or- <b>Measles #1</b> ____/____/____ <b>Measles#2</b> ____/____/____  <b>Mumps #1</b> ____/____/____ <b>Mumps #2</b> ____/____/____  <b>Rubella #1</b> ____/____/____ <b>Rubella #2</b> ____/____/____ -or- Attached lab report showing positive immunity			
<b>Hepatitis B #1</b> ____/____/____ <b>Hepatitis B #2</b> ____/____/____ (30 days after dose 1) <b>Hepatitis B #3</b> ____/____/____ (Given 4 months after dose 2) Immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.			
<b>Varicella #1</b> ____/____/____ <b>Varicella #2</b> ____/____/____ (given at least 30 days after dose 1) -or- Attached lab report showing positive immunity			
For students living on campus or in university sponsored housing: <b>Meningococcal</b> ____/____/____      ____Menactra      ____Menomune -or- Attached Meningitis waiver found on the forms section of the Student Health Center Web site.			
<b>Additional Requirement for Students 17 and under:</b> <b>Polio#1</b> ____/____/____ <b>Polio #2</b> ____/____/____ <b>Polio #3</b> ____/____/____ -or- Attached lab report showing positive immunity			

\_\_\_\_\_  
**Healthcare Provider Signature/Title/Phone Number**

\_\_\_\_\_  
**Date**

**OFFICE STAMP**

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

**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	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
Anguilla	Central African Rep.	Georgia	Latvia	Nauru	The Grenadines	Tokelau
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

**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