

Medical Requirement Form

**This form MUST be completed and RETURNED to Curry Health Center PRIOR to orientation/registration
Call or email us if you still have questions after viewing our website**

Use Ink Only, Please Print SOC SEC# _____ STUDENT ID# _____

Name _____ / _____ / _____ Age _____ Date of Birth ____/____/____
Last Name First Name in Full Middle

Current Mailing Address _____ _____ _____ _____ _____
Street City State Country Zip

Telephone # _____ E-mail Address _____ Sex M F

Previously enrolled at the University of Montana? YES NO If YES, under what name? _____ Last Year Attended _____

I. MMR VACCINATION REQUIREMENT (Required by Montana Law)

- **Born prior to January 1, 1957 - Please attach proof of age (State ID issued card, driver's license, school transcript with date of birth, birth certificate, or passport)**
- **Born later than December 31, 1956, please complete the following:**

Have this section completed and signed by a health care provider.

OR

Attach to this form a legible 'copy' of an **official immunization record** (medical record, high school, etc.) or **official copy of blood test**. Mail or Fax to Curry Health Center (CHC). Do **NOT** send originals.

MMR (Measles, Mumps, Rubella)

Dose 1 – Immunized at least 12 months after birth or later
Dose 2 – Immunized at least 30 days after Dose 1

Date
____/____/____
____/____/____

OR

MEASLES (rubeola) If given instead of MMR

Two doses of vaccine given after 1971

1st dose after age 12 mo. 2nd dose at least 30 days later
1st dose **Date** ____/____/____ 2nd dose **Date** ____/____/____

OR

Certification by physician of having the disease. **rubeola**

Date of disease ____/____/____

OR

Blood test (titer) indicating immunity to **rubeola**

Date of test ____/____/____ **Results:** _____

RUBELLA If given instead of MMR

Two doses of vaccine given after 1971

1st dose after age 12 mo. 2nd dose at least 30 days later
1st dose **Date** ____/____/____ 2nd dose **Date** ____/____/____

OR

Certification by physician of having the disease. **rubella**

Date of disease ____/____/____

OR

Blood test (titer) indicating immunity to **rubella**

Date of test ____/____/____ **Results:** _____

Signature and title required if completed by a health care provider

Provider Signature & Title _____ Phone _____ Date _____

II. ACCESS to Montana's Immunization Data Bank (ImMTrax)

I grant Curry Health Center access to view my immunization records via ImMTrax

Student Signature _____ Date _____

Please turn OVER - Must complete back page

III. Tuberculosis (TB) Screening Questionnaire

Please read the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease?
2. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?
3. 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 – medically underserved, low-income, or abusing drugs or alcohol?
4. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?
5. Were you born or had frequent or prolonged visits to one of the countries listed below?

If yes, please **CIRCLE** the country, below

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata>.

If you answered:

'Yes' to one or more of the above questions

If the answer is YES - University of Montana requires proof of TB testing done in a United States medical facility. This may be done at Curry Health Center. Acceptable tests are: PPD skin tests (if positive include reading in millimeters), QuantiFERON or T-SPOT.

'No' to questions 1-5

If the answer to all of the above questions is NO, no further testing or further action is required.

Source: ACHA Guidelines for Tuberculosis Screening and Targeted Testing of College and University Students. April 2014