

Immunization Requirement

**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 mm dd yy

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) otherwise 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 _____ / _____ / _____
mm dd yy

Dose 2 – Immunized at least 30 days after Dose 1 _____ / _____ / _____
mm dd yy

> **OR**

MEASLES (rubeola) **If given instead of MMR** **RUBELLA** **If given instead of MMR**

Two doses of vaccine given after 1966 Two doses of vaccine given after 1968

1st dose after age 12 mo. 2nd dose at least 30 days later **AND** 1st dose after age 12 mo. 2nd dose at least 30 days later
1st dose **Date** _____ / _____ / _____ 2nd dose **Date** _____ / _____ / _____ 1st dose **Date** _____ / _____ / _____ 2nd dose **Date** _____ / _____ / _____
mm dd yy mm dd yy mm dd yy mm dd yy

OR

OR

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

Date of disease _____ / _____ / _____ **Date of disease** _____ / _____ / _____
mm dd yy mm dd yy

OR **OR**

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

Date of test _____ / _____ / _____ **Results:** _____ **Date of test** _____ / _____ / _____ **Results:** _____
mm dd yy mm dd yy

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

NAME: _____ D.O.B.: _____ Student ID#: _____

III. Tuberculosis (TB) Screening Questionnaire

Please read the following questions:

1. Have you ever been in close contact with someone known to have active TB disease?
2. Have you ever used intravenous drugs or had a history of alcoholism?
3. Have you ever resided, worked, or volunteered in a hospital, nursing home, prison, homeless shelter, or other long-term treatment facility?
4. Were you born or had frequent or prolonged visits to one of the countries listed below?
If yes, please CIRCLE the country, below:

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to https://www.acha.org/documents/resources/guidelines/ACHA_Tuberculosis_Screening_April2022.pdf

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 2022.