ORANGE COAST COLLEGE HOUSING IMMUNIZATION RECOMMENDATIONS

Name:	Date of Birth: (MM/DD/YYYY)	Student ID:
First Last		

RECOMMENDED IMMUNIZATIONS	
MMR Vaccine • Measles, Mumps & Rubella	**YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.** **(Dose 1 & 2 must be AT LEAST 28 days apart)** Measles Dose 1 Date:_____ Mumps Dose 1 Date:_____Rubella Dose 1 Date:_____ Measles Dose 2 Date: _____Mumps Dose 2 Date:_____Rubella Dose 2 Date:_____ **IF UNABLE TO OBTAIN PROOF OF VACCINATION, YOU MUST OBTAIN A BLOOD TITER TEST.** *** ATTACH A COPY OF YOUR LAB REPORT.** **POSITIVE Measles IgG Antibody Titer** Date: _____ **POSTIVE Mumps IgG Antibody Titer** Date: _____ **POSITIVE Rubella IgG Antibody Titer** Date: _____ • If you have a negative or indeterminate titer, obtain one dose of MMR and repeat titer 4 weeks later. If titer is still negative, receive a 2nd dose of MMR.
Varicella (Chicken Pox) Vaccine	**YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.** Dose 1 Date:_____**(must be on or after your 1st birthday)** **(Dose 1 & 2 must be AT LEAST 28 days apart)** Dose 2 Date: _____ **IF YOU HAD THE DISEASE AS A CHILD OR IF YOU ARE UNABLE TO OBTAIN PROOF OF VACCINATION, YOU MUST OBTAIN A BLOOD TITER TEST.** **POSITIVE Varicella IgG Antibody Titer** Titer Date: _____ • If you have a negative or indeterminate titer, obtain one dose of Varicella vaccine and repeat titer 4 weeks later. If titer is still negative, receive a 2nd dose of Varicella.
Tdap Vaccine • Tetanus/Diphtheria WITH Pertussis (whooping cough)	**ONE DOSE ON OR AFTER THE 7TH BIRTHDAY** Dose Date: _____ **(Please note: The recommendation is Tdap and not Td nor Dtap)**
Meningococcal Vaccine • MCV4 (Menactra or Menveo) for students 21 years or younger	**THE MOST RECENT DOSE MUST BE ON OR AFTER THE 16TH BIRTHDAY.** Dose 1 Date: _____ Dose 2 Date: _____
Seasonal Influenza (Flu) Vaccine	**ONE DOSE ON OR AFTER AUGUST OF CURRENT YEAR** Dose Date: _____

ORANGE COAST COLLEGE TUBERCULOSIS (TB) CLEARANCE FORM

Name:	Date of Birth: (MM/DD/YYYY)	Student ID:

First Last

For incoming housing students who answered "YES" to any of the questions on the *Tuberculosis Risk Assessment* on the Student Health Portal. TB testing and/or Chest Xray should be done within 6 months of the move-in date. DO NOT REPEAT TB TEST IF YOU HAVE HISTORY OF A POSITIVE TB TEST. Those with a previous positive TB Test are recommended to submit documentation of a Chest Xray within 6 months of the move-in date.

TUBERCULIN SKIN TEST (TST)	**TB BLOOD TEST (Recommended if history of BCG/TB Vaccine)**
ONE SKIN TEST REQUIRED **Date placed**:_____**Date read**:_____ (must be read between 48-72hrs after it was placed) **Result**:_____mm induration. Interpretation: ☐ **Negative** ☐ **Positive** **(IF POSITIVE, PROCEED TO SYMPTOMS & CHEST X-RAY)**	**QUANTIFERON or T-SPOT** **(Interferon Gamma Release Assay – IGRA)** If not available, may do a Tuberculin Skin Test (TST)-ray. **Date QTF/T-SPOT Test**: _____ Result: ☐ **Negative** ☐ **Positive** **(IF POSITIVE, PROCEED TO SYMPTOMS & CHEST X-RAY)**

SYMPTOMS:

Does your patient have any of the following symptoms? (please check any that apply)

- ☐ Cough for greater than 4weeks
- ☐ Unexplained Chest pain
- ☐ Persistent fever/chills/night sweats
- ☐ Coughing up blood
- ☐ Unexplained weight loss
- ☐ Persistent, unexplained fatigue

CHEST X-RAY (REQUIRED if Positive TST or QuantiFERON/IGRA OR Symptoms are positive OR previous treatment for TB)

Date of Chest X-ray:_____ **Result:** ☐ Normal ☐ Abnormal

MUST ATTACH <u>WRITTEN</u> RADIOLOGY CHEST XRAY REPORT NOTING "NO ACTIVE TUBERCULOSIS." (DO NOT SEND FILMS/CD of actual X-ray). REPORT MUST BE IN ENGLISH.

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE.

Provider's Signature:_____Practice Stamp:

Provider's Name:_____(DO/MD/PA/NP) Date: _____