

ORANGE COAST COLLEGE HOUSING IMMUNIZATION RECOMMENDATIONS

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|-------------------|------------|-----------------------------------|-------------------|
| Name: First _____ | Last _____ | Date of Birth: (MM/DD/YYYY) _____ | Student ID: _____ |
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| RECOMMENDED IMMUNIZATIONS | |
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| MMR Vaccine <ul style="list-style-type: none"> Measles, Mumps & Rubella | <p>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)</p> <p>Measles Dose 1 Date: _____ Mumps Dose 1 Date: _____ Rubella Dose 1 Date: _____</p> <p>Measles Dose 2 Date: _____ Mumps Dose 2 Date: _____ Rubella Dose 2 Date: _____</p> <p>IF UNABLE TO OBTAIN PROOF OF VACCINATION, YOU MUST OBTAIN A BLOOD TITER TEST. * ATTACH A COPY OF YOUR LAB REPORT.</p> <p>POSITIVE Measles IgG Antibody Titer Date: _____</p> <p>POSTIVE Mumps IgG Antibody Titer Date: _____</p> <p>POSITIVE Rubella IgG Antibody Titer Date: _____</p> <ul style="list-style-type: none"> 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 | <p>YOU MUST HAVE 2 DOSES WITH THE FIRST DOSE BEING ON OR AFTER YOUR FIRST BIRTHDAY.</p> <p>Dose 1 Date: _____ (must be on or after your 1st birthday) (Dose 1 & 2 must be AT LEAST 28 days apart)</p> <p>Dose 2 Date: _____</p> <p>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.</p> <p>POSITIVE Varicella IgG Antibody Titer</p> <p>Titer Date: _____</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Tetanus/Diphtheria WITH Pertussis (whooping cough) | <p>ONE DOSE ON OR AFTER THE 7TH BIRTHDAY</p> <p>Dose Date: _____</p> <p>(Please note: The recommendation is Tdap and not Td nor Dtap)</p> |
| Meningococcal Vaccine <ul style="list-style-type: none"> MCV4 (Menactra or Menveo) for students 21 years or younger | <p>THE MOST RECENT DOSE MUST BE ON OR AFTER THE 16TH BIRTHDAY.</p> <p>Dose 1 Date: _____</p> <p>Dose 2 Date: _____</p> |
| Seasonal Influenza (Flu) Vaccine | <p>ONE DOSE ON OR AFTER AUGUST OF CURRENT YEAR</p> <p>Dose Date: _____</p> |

ORANGE COAST COLLEGE TUBERCULOSIS (TB) CLEARANCE FORM

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| Name: First _____ Last _____ | Date of Birth: (MM/DD/YYYY) _____ | Student ID: _____ |
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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) | | |
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| <p>ONE SKIN TEST REQUIRED</p> <p>Date placed: _____ Date read: _____ (must be read between 48-72hrs after it was placed)</p> <p>Result: _____ mm induration.</p> <p>Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p> <p>(IF POSITIVE, PROCEED TO SYMPTOMS & CHEST X-RAY)</p> | <p>QUANTIFERON or T-SPOT</p> <p>(Interferon Gamma Release Assay – IGRA)</p> <p>If not available, may do a Tuberculin Skin Test (TST)-ray.</p> <p>Date QTF/T-SPOT Test: _____</p> <p>Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p> <p>(IF POSITIVE, PROCEED TO SYMPTOMS & CHEST X-RAY)</p> | | |
| <p>SYMPTOMS:</p> <p>Does your patient have any of the following symptoms? (please check any that apply)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Cough for greater than 4weeks <input type="checkbox"/> Unexplained Chest pain <input type="checkbox"/> Persistent fever/chills/night sweats </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Persistent, unexplained fatigue </td> </tr> </table> | | <input type="checkbox"/> Cough for greater than 4weeks <input type="checkbox"/> Unexplained Chest pain <input type="checkbox"/> Persistent fever/chills/night sweats | <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Persistent, unexplained fatigue |
| <input type="checkbox"/> Cough for greater than 4weeks <input type="checkbox"/> Unexplained Chest pain <input type="checkbox"/> Persistent fever/chills/night sweats | <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Persistent, unexplained fatigue | | |
| <p>CHEST X-RAY (REQUIRED if Positive TST or QuantiFERON/IGRA OR Symptoms are positive OR previous treatment for TB)</p> | | | |
| <p>Date of Chest X-ray: _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p style="text-align: center;">MUST ATTACH WRITTEN RADIOLOGY CHEST XRAY REPORT NOTING "NO ACTIVE TUBERCULOSIS." (DO NOT SEND FILMS/CD of actual X-ray). REPORT MUST BE IN ENGLISH.</p> | | | |

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| <p>I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE.</p> | |
| Provider's Signature: _____ | Practice Stamp: _____ |
| Provider's Name: _____ (DO/MD/PA/NP) Date: _____ | |