The University of Iowa requires verification of **Measles, Mumps, Rubella (MMR)** immunization or immunity for students born after 12/31/56. This requirement is fulfilled if you meet one of the following criteria:

- [] I was born before 1957; **OR**
- [] I provide Student Health & Wellness copies of original lab reports of MMR titers that verify immunity; **OR**
- [] I received 2 doses of MMR vaccine **after your first birthday**
  - MMR #1__________  MMR #2____________ (must be at least 28 days after first MMR)

You will have one semester to provide Student Health & Wellness with validation of your immunity to MMR. **You will not be allowed to register for subsequent semesters until you have complied.** These vaccinations are available at Student Health & Wellness for a fee.

**ALL STUDENTS:**

**IMMUNIZATION INFORMATION MUST BE VALIDATED BY THE SIGNATURE OF YOUR PHYSICIAN, NURSE, OR IMMUNIZING OFFICIAL.**

The University of Iowa requires documentation of all the immunizations in **BOLD** below. Those that are starred (**) are optional.

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**Chickenpox** (Varicella). Proof of immunity may be established by having:

- [] I had vaccination series - (month, day, year) given: #1_____ / _____ / _____; #2_____ / _____ / _____; **OR**
- [] I had the disease - (month, day, year) _____ / _____ / _____

**Tetanus, Diphtheria**

- [] I had Td (valid only if within 10 years) - (month, day, year) given _____ / _____ / _____; **OR**
- [] I had Tdap (valid only if within 10 years) - (month, day, year) given _____ / _____ / _____

**Polio** – (month, day, year) given: _____ / _____ / _____

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**Hepatitis B**

- [] I had Hepatitis B Series (month, day, year) given: #1_____ / _____ / _____; #2_____ / _____ / _____; #3_____ / _____ / _____; **OR**
- [] I had Hepatitis A/B Combination Series (month, day, year) given: #1_____ / _____ / _____; #2_____ / _____ / _____; #3_____ / _____ / _____

**Hepatitis B antibody titre.** (Provide a copy of the original lab report). If non-immune, boosters required according to protocol.

**Tuberculin skin test (TST)** (PPD intradermally). TST is valid only if read 48-72 hours from the time it was placed.

- [] I had TST given: _____ / _____ / _____; date read: _____ / _____ / _____; Result: **[] negative  [] positive** mm; **OR**
- [] I had interferon gamma release assay (IGRA) test i.e., Quantiferon TB Gold Test (QFT-G) or T-SPOT.TB drawn: _____ / _____ / _____; Result: **[] negative  [] positive**

If your TB screening test is positive, please provide a copy of your chest X-ray report and treatment record if you have had or are on INH.

**Hepatitis A** series (month, day, year) given: #1_____ / _____ / _____; #2_____ / _____ / _____

**Signature of your physician, nurse, or immunizing official is required.**

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The tests and immunizations below are encouraged, but not required for most students.

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**Legal Name** ____________________________ **University ID #** ____________________________ **Birth Date**: Month ________ / Day________ / Year____________ **Address** ____________________________