UST RESIDENTIAL Immunization Form

Student Name: First _____ Last _____ MI _____

Student ID #: _____ Date of Birth: ___/___/____ Date of UST Entry: ___/___/____

You must have a health care provider complete and sign this form OR you may submit a copy of your official immunization records.

UNIVERSITY OF ST. THOMAS

Upload this document to your Application Status Portal:
https://myust.stthom.edu/portal/apply

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Please direct questions to immunizations@stthom.edu

REQUIRED IMMUNIZATION FOR ALL NEW STUDENTS under age 22.

This information does not apply to students 22 years of age or older and students enrolled only in online or other distance courses.

Month/Day/Year

MENINGOCOCCAL MENINGITIS
Must have had the meningitis immunization (MPSV4 or MCV4) **NOT Meningitis B** ___/___/____
After 16th birthday & within the last 5 years prior to enrollment

All immunizations listed below are REQUIRED FOR ALL RESIDENTIAL STUDENTS

M.M.R. (Measles, Mumps, Rubella) (Two doses required) **Month/Day/Year**

A. Dose 1 given on or after 1st birthday, AND on or after January 1, 1957 ___/___/____

B. Dose 2 given 15 months after birth or later, and at least 28 days after first dose ___/___/____

TETANUS DIPHTHERIA (Td booster in the last **TEN** years meets requirement)

Tetanus Diphtheria (Td) or tdap booster within the last **ten years**. ___/___/____

TUBERCULOSIS TEST (Required for all on-campus residents. Note: international students must have been tested within the last 12 months prior to moving into campus housing. Domestic students can be from any year).

Result: Neg ___ Pos ___ mm induration (horizontal diameter) ____ ___/___/____

If PPD is positive, chest X-ray required: X-ray result: Normal ____Abnormal ____ ___/___/____

If PPD is positive have you had INH prophylaxis? No ____Yes ____Date completed_____

Note: ***If you are living on campus there is a 10 day waiting period from the time the meningitis vaccination is received to be allowed to move into the residence halls.***

Signature of Health Care Provider: _____ **Date:**_____

Printed Name of Health Care Provider / Clinic: _____

Health Care Provider/ Clinic Phone #: _____