DELAWARE
COLLEGE OF ART
AND DESIGN

IMMUNIZATION
RECORD

STUDENT'S NAME _____ DATE OF BIRTH _____/_____/_____
last first m.i. *month / day / year*

At the Delaware College of Art and Design (DCAD), we are concerned about your health and well being. To comply with Delaware Department of Health regulations and to prevent health emergencies the information requested on this form must be completed and submitted with physician certificates and/or signed by your health provider. All information must be provided in English. Please print.

Please note that students will not be permitted to attend classes unless Page 1 of this form and/or the appropriate waiver forms are completed and returned.

Return to:
STUDENT SERVICES
DCAD
600 N MARKET ST
WILMINGTON, DE 19801

1. REQUIRED IMMUNIZATIONS *unless waiver form is completed and attached*

MMR (MEASLES, MUMPS, RUBELLA) ***if given instead of individual immunizations*** — ***Month/Day/Year***

- ☐ Dose 1 – Immunized at 12 months or after and before five years; and, ___/___
- ☐ Dose 2 – Immunized at five years or later ___/___

OR ***all three following individual immunizations:***

MEASLES (RUBEOLA)

- ☐ Born before 1956 and therefore considered immune; or, ___/___
- ☐ Has report of immune titer; specify titer _____; or, ___/___
- ☐ Dose 1 – Live measles vaccination at 15 months or later; and ___/___
- ☐ Dose 2 – Live measles vaccination at five years or later. ___/___

GERMAN MEASLES (RUBELLA)

- ☐ Has report of immune titer; specify titer _____; or, ___/___
- ☐ Immunized with vaccine at 12 months after birth or later. ___/___

MUMPS

- ☐ Had disease; confirmed by office record; or, ___/___
- ☐ Immunized with vaccine at 12 months after birth or later. ___/___

TETANUS – DIPHTHERIA

- ☐ Completed primary series of tetanus-diphtheria immunizations; and, ___/___
- ☐ Received tetanus-diphtheria booster within the last ten years. ___/___

MENINGOCOCCAL MENINGITIS ***required unless waiver form is signed on page 3***

- ☐ Review information and requirements on page 3 of 4.

TUBERCULOSIS ***required if student fits one or both categories on Page 2***

- ☐ I do not fit either category requiring tuberculosis screening; or, ___/___
- ☐ PPD (Mantoux) test within six months; test result _____; or, ___/___
- ☐ Positive PPD; chest x-ray required; X-ray result _____; or, ___/___
- ☐ Had BCG vaccine; chest X-ray required if PPD not done. ___/___

STRONGLY RECOMMENDED IMMUNIZATIONS

- ☐ Polio *enter date of primary series or last booster, whichever is later* ___/___
- ☐ Hepatitis B *enter date of series or last booster, whichever is later* ___/___
- ☐ Varicella (Chicken Pox) *enter date of vaccine, disease or antibody titer* ___/___
- ☐ Covid-19 *enter date of vaccine, or last booster, whichever is later* ___/___

HEALTH CARE PROVIDER INFORMATION

NAME _____ SIGNATURE _____

ADDRESS _____

DATE _____ PHONE _____

302 622 8000
302 622 8870 FAX
WWW.DCAD.EDU

2. TUBERCULOSIS INFORMATION

Testing and treatment for tuberculosis is only required for students fitting one or both of the following categories.

CATEGORY I

High-risk students include those who have arrived in the US within the past five years from countries where tuberculosis is endemic. All countries in the African Region, Eastern Mediterranean Region, Southeast Asian Region, and Russia are considered high risk.

Students from the following countries are not required to be tested:

USA	Germany	Malta	Sweden
American Samoa	Greece	Monaco	Switzerland
Australia	Iceland	Netherlands	United Kingdom
Belgium	Ireland	New Zealand	Virgin Islands
Canada	Italy	Norway	
Denmark	Jamaica	Saint Kitts and Nevis	
Finland	Liechtenstein	Saint Lucia	
France	Luxembourg	San Marino	

CATEGORY II

Those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregated settings such as prisons, nursing homes, hospitals, residential facilities or patients with AIDS or the homeless or students who have the following clinical conditions:

- Diabetes, chronic renal failure leukemias or lymphomas
- Low body weight, gastrectomy and jejunoileal bypass
- Chronic malabsorption syndromes
- Prolonged corticosteroid therapy (e.g. prednisone, > 15mg/day for more than a month)
- Other immuno-suppressive disorders

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STUDENT'S NAME_____ DATE OF BIRTH _____/_____/_____
last first m.i. *month / day / year*

On June 6, 2001, Governor Ruth Ann Minner signed legislation in Delaware requiring colleges and universities to provide information to admitted students about Meningococcal Meningitis and to provide notice of the availability and benefits of the vaccination. That legislation also requires colleges and universities to record the informed Meningococcal Meningitis vaccination decision made by the student or the student's parent/guardian. Additional information is available from the Centers for Disease Control website at http://www.cdc.gov/ncidod/dbmd/meningitis/

Students who decide not to be immunized for Meningococcal Meningitis will not be permitted to attend classes unless this form is completed.

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3. MENINGOCOCCAL MENINGITIS INFORMATION

Meningitis is an infection of the fluid of a person's spinal cord and the fluid that surrounds the brain. People sometimes refer to it as spinal meningitis. Meningitis is usually caused by a viral or bacterial infection. Knowing whether meningitis is caused by a virus or bacterium is important because the severity of the illness and the treatment differ. Viral meningitis is generally less severe and resolves without specific treatment, while bacterial meningitis can be quite severe and may result in brain damage, hearing loss, or learning disability. For bacterial meningitis, it is also important to know which type of bacteria is causing the meningitis because antibiotics can prevent some types from spreading and infecting other people. Before the 1990s, Haemophilus influenzae type b (Hib) was the leading cause of bacterial meningitis, but new vaccines being given to all children as part of their routine immunizations have reduced the occurrence of invasive disease due to H. Influenzae. Today, Streptococcus pneumoniae and Neisseria eningitides are the leading causes of bacterial meningitis.

High fever, headache, and stiff neck are the common symptoms of Meningitis in anyone over the age of 2 years. These symptoms can develop over several hours, or they may take 1 to 2 days. Other symptoms may include nausea, vomiting, discomfort looking into bright lights, confusion and sleepiness. As the disease progresses, patients of any age may have seizures. Early diagnosis and treatment is very important. If these symptoms occur, the patient should see a doctor immediately.

Bacterial meningitis can be treated with a number of effective antibiotics. It is important, however, that treatment be started early in the course of the disease. Appropriate antibiotic treatment of most common types of bacterial meningitis should reduce the risk of dying from meningitis to below 15%. Some forms of bacterial meningitis are contagious. The bacteria are spread through the exchange of respiratory and throat secretions (i.e. coughing, kissing). There are vaccines against Hib and against some strains of N. eningitides and many types of Streptococcus pneumoniae. The vaccines against Hib are very safe and highly effective. Side effects of this vaccines are mild and infrequent, usually only redness or swelling at the injection site. As with any vaccine there is a risk of hypersensitivity/allergic reaction.

College freshmen, particularly those who live in residence halls, are at modestly increased risk for meningococcal disease relative to other persons their age. Vaccination with the currently available quadrivalent meningococcal polysaccharide vaccine will decrease the risk for meningococcal disease among such persons.

***New CDC Recommendations (3/11)** All adolescents and teens ages 11 through 18 years should be vaccinated with Menactra or Menveo, as should unvaccinated young adults19 through 21 years who are attending college. Booster doses are recommended by CDC for those who got their first dose before age 16 years.

MENINGOCOCCAL MENINGITIS VACCINE*

M Menactra Vaccine Dates (conjugate) #1_____/_____/_____, #2_____/_____/_____
M D Y M D Y

M Menveo Vaccine Dates (conjugate) #1_____/_____/_____, #2_____/_____/_____
M D Y M D Y

M Menomune Vaccine Dates #1_____/_____/_____, #2_____/_____/_____

STUDENT WAIVER & RELEASE

I have read the above information and have decided not to be vaccinated. I release the Delaware College of Art and Design and its employees from any responsibility for any impairment of my health resulting from this waiver. If student is under 18, parent or guardian must also sign.

STUDENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN _____ DATE _____

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STUDENT'S NAME _____ DATE OF BIRTH _____/_____/_____
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Students may request a waiver from the required immunizations for either medical or religious reasons. If such a waiver is requested, please complete the appropriate portion of this form. Note that the medical waiver must be certified by a health care professional and the religious waiver by the appropriate clergy. All information must be provided in English. Please print.

Please note that students who do not complete the Immunization Form will not be permitted to attend classes unless this form is completed.

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4. MEDICAL WAIVER

The student named above should be exempt from the following required immunizations because administration of the immunizing agents listed below would be detrimental to the student's health.

☐	MMR (Measles, Mumps, Rubella)	*specify immunizing agent*	_____
☐	Measles (Rubeola)	*specify immunizing agent*	_____
☐	German Measles (Rubella)	*specify immunizing agent*	_____
☐	Mumps	*specify immunizing agent*	_____
☐	Tetanus - Diphtheria	*specify immunizing agent*	_____
☐	Meningococcal Meningitis	*specify immunizing agent*	_____
☐	Tuberculosis (if required)	*specify immunizing agent*	_____
☐	Covid-19 (if required)	*specify immunizing agent*	_____

HEALTH CARE PROVIDER CERTIFICATION

NAME _____ SIGNATURE _____

ADDRESS _____

DATE _____ PHONE _____

OR

RELIGIOUS WAIVER

CLERGY CERTIFICATION

The student named above should be exempt from the required immunizations because of his/her religious beliefs.

CLERGY'S SIGNATURE _____

CLERGY'S PRINTED NAME _____ DATE _____

STUDENT WAIVER & RELEASE

I have read the above information and have decided not to be vaccinated. I release the Delaware College of Art and Design and its employees from any responsibility for any impairment of my health resulting from this waiver. If student is under 18, parent or guardian must also sign.

STUDENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN _____ DATE _____

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