

Do Not Upload This Page

University: University of Evansville - international student

Student: _____ DOB: _____

HOW TO COMPLETE THESE FORM(S):

- A licensed healthcare professional **MUST** complete and sign **THESE** forms. **All green sections are required.**
- Other forms of health records containing the required health information will be accepted.**
- PRINT CLEARLY WITH DARK BLACK INK.** A computer will be reading your forms. Fill in circles completely.
- Do not fold, cut, or mark on the border lines of these forms.
- Include the Border Lines in your scanned images.
- Review your forms for completeness and accuracy. Double check **ALL** signatures. **MM/DD/YY date formats.**
- Consult your Healthcare Professional before receiving any of the following immunizations.

Your records are due by: July 1 for Fall Semester and December 1 for Spring Semester.

REQUIRED	RECOMMENDED	OPTIONAL
Required by regulation and/or policy to attend this university.	Recommended for your general well being but NOT required.	Optional information.
<p>Documents:</p> <p>Immunization Certificate (see page 2)</p> <p>Immunization Dates:</p> <p>TDaP Booster (1 dose within last 10 yrs)</p> <p>MMR (2 doses OR Pos. Titer)</p> <p>Meningococcal (21 years of age or younger require 1 dose @ age 16 or older)</p> <p>TB Blood Test: QuantiFERON or T-spot:</p> <p>Results must be performed within 6 months of the start of the semester. A TB skin test is not an acceptable form of testing.</p>	<p>Immunization Dates:</p> <p>Varicella</p> <p>Polio</p> <p>Hepatitis A</p> <p>Hepatitis B</p> <p>HPV</p> <p>Meningococcal B</p> <p>COVID</p>	<p>Immunization Dates:</p> <p>Pneumococcal</p> <p>JE - Japanese Encephalitis Typhoid</p> <p>Yellow Fever</p> <p>Rabies</p>

UPLOADING YOUR FORM(S):

- Review your forms for completeness and accuracy. **Double check ALL signatures.**
- Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- Upload your completed forms to your account at medproctor.com.
- You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- Check your University Email account regularly for messages from MedProctor regarding incomplete information.

You will be notified via email once your information is successfully verified.

BE AWARE:

- * Incomplete/illegible writing and poor images will be rejected.
- * Completion of these forms by your due date will help expedite your registration process.

Should you require medical/religious exemptions, please contact UE Student Health Center at 812-488-2033 or email healthcenter@evansville.edu

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IMMUNIZATION CERTIFICATE



PRINT CLEARLY WITH DARK BLACK INK.
 Must be completed by a healthcare professional.
 This form will be read by a computer.
 Upload to medproctor.com

Green = Required
 Blue = Recommended
 Black = Optional

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TDaP - Booster Required Within 10 yrs. MM DD YY	HEPATITIS B Recommended 1st MM DD YY 2nd MM DD YY 3rd MM DD YY	VARICELLA - Chicken Pox Recommended 1st MM DD YY 2nd MM DD YY	TYPHOID - Inactivated Optional One MM DD YY
MMR Required Measles, Mumps, Rubella 1st MM DD YY 2nd MM DD YY	HPV Recommended Human Papillomavirus 1st MM DD YY 2nd MM DD YY 3rd MM DD YY	HEPATITIS A Recommended 1st MM DD YY 2nd MM DD YY	YELLOW FEVER Optional One MM DD YY
MENINGOCOCCAL Required 1st MM DD YY 2nd MM DD YY	COVID Recommended 1st MM DD YY 2nd MM DD YY 3rd MM DD YY	POLIO Recommended Inactivated 1st MM DD YY 2nd MM DD YY 3rd MM DD YY 4th MM DD YY	RABIES - Pre-Exposure Optional 1st MM DD YY 2nd MM DD YY 3rd MM DD YY
MENINGOCOCCAL B Recommended 1st MM DD YY 2nd MM DD YY			

REQUIRED - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARD PROFESSIONAL SIGNATURE	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NON-PARENTAL	_____	_____
NPI NUMBER <small>not required for U.S. service members or international students</small>	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER
_____	_____	_____-_____-_____

REQUIRED - TB Blood test (QuantIFERON or T-Spot)

TB Blood T-Spot QuantIFERON Test MM DD YY	Results ● Positive ● Negative
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Please submit blood test results if possible.
 A TB skin test is not an acceptable form of test.

REQUIRED - Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARD PROFESSIONAL SIGNATURE	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NON-PARENTAL	_____	_____
NPI NUMBER <small>not required for U.S. service members or international students</small>	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER
_____	_____	_____-_____-_____

OFFICE STAMP
 (Not required if stamp unavailable.)

