International Student Health Certificate

This form, or an official immunization record, may be used to verify immunizations and test results that are required for all California State University students. Please submit at new student orientation.

Name (Last, First): __________________________________________ CSUC ID: ______________________________

Date of Birth: ______________________ Gender (check box): ☑ Male  ☐ Female

The following is to be filled out by a physician:

1. Measles/Rubella (MMR) Immunization (choose one of the following)
   ___ a. First Dose: Second Dose (if any):  (Month / Day / Year)  (Month / Day / Year)
   ___ b. Date of Positive Measles and Rubella Serologic Test (if applicable):  (Month/Day/Year)

2. Hepatitis B (3 shot series)
   (If you are 18 years or younger on the first day of classes)  (Month / Day / Year)  (Month / Day / Year)  (Month / Day / Year)

   Name of Clinic/Hospital: __________________________________________________________________________________

   Address of Clinic/Hospital: __________________________________________________________________________________

   Signature of Physician (required): __________________________________________ Date: ______________________________ (Month / Day / Year)

3. Tuberculin Examination (choose one of the following)
   ___ a. Skin Test Results (cannot be older than 90 days before travel to U.S.)
      ☐ Positive  (Please indicate the size of reaction):  
      ☐ Negative—Revealed (No abnormalities)
   ___ b. Quantiferon Tuberculin Screen Test (cannot be older than 90 days before travel to U.S.)
      ☐ Positive
      ☐ Negative

      Important: Quantiferon test may be requested at the Student Health Center during new student orientation for an additional fee, approximately $55. (Amount is subject to change.)

   Name of Clinic/Hospital: __________________________________________________________________________________

   Address of Clinic/Hospital: __________________________________________________________________________________

   Signature of Physician (required): __________________________________________ Date: ______________________________ (Month / Day / Year)

Revised: September 2017