California State University, Chico

Chico, California 95929-0777
WellCat Health Center Phone: +1 530-898-5241 FAX: +1 530-898-4057
Accredited by Accreditation Association of Ambulatory Health Care

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. ***Students: Upload completed form to your WellCat Health Center Patient Portal.***

Name **(Last, First):** _____ Student ID: _____

Date of Birth: _____Gender **(check box):** ❑Male ❑Female ❑Non-Binary ❑ Refuse to State
(Month / Day / Year)

The following is to be filled out by a physician:

Measles/Mumps/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, Mumps, Rubella Serologic Test **(if applicable):** _____
(Month / Day / Year)

Varicella (chicken pox)

(choose one of the following)

___ **a.** First Dose_____ Second Dose (if any) _____
(Month / Day / Year) (Month / Day / Year)

___ **b.** Date of Positive Varicella Serologic Test **(if applicable):** _____
(Month / Day / Year)

Tetanus, Diphtheria and Pertussis (Tdap)

___ **a.** Recent Dose_____
(Month / Day / Year)

Vaccine must contain pertussis, one dose within the last 10 years or 1 dose after the age of 7 years.

Meningococcal B (Meningitis B)

___ **a.** First Dose_____ Second Dose (if any) _____
(Month / Day / Year) (Month / Day / Year)

A two or three shot series ages 16 through 23.

Hepatitis B (3 shot series)

First Dose_____ Second Dose _____ Third Dose _____
(Month / Day / Year) (Month / Day / Year) (Month / Day / Year)

If you are 18 years old or younger on the first day of classes of your first semester at CSU, Chico, you are required to meet the three-shot Hepatitis B immunization requirement. Even if you turn 19 years of age during your first year of enrollment at the University, you are still responsible for completing the Hepatitis B immunization requirement.

Tuberculin Examination

Has the above student received the BCG vaccine for tuberculosis?
❑YES ❑NO
If **YES**, please provide:
___ **a QuantiFERON Tuberculin Screen**
(cannot be older than 90 days before travel to U.S.)
❑ Positive ❑ Negative

If **NO** 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 Chest X-Ray**
(cannot be older than 90 days before travel to U.S.)
❑ Positive ❑ Negative

I attest that all dates and immunizations listed on this form are correct and accurate.

Name of Clinic/Hospital: _____

Address of Clinic/Hospital: _____

Signature of Physician (required)_____ **Date:** _____
(Month / Day / Year)

Provider's Name _____ License #: _____