California State University Chico

Chico, California 95929-0777
Student Health Service Phone: 530-898-5241 FAX: 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. Please submit at new student orientation.

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

Date of Birth: _____ Gender **(check box) :** ☐ Male ☐ Female
(Month / Day / Year)

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)

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.

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)