Please email a completed copy to iep@csusb.edu

and bring the original document with you to the USA.

<u>Immunization Documentation</u>

ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED AND SIGNED IN <u>ENGLISH</u> BY YOUR HEALTH CARE PRACTITIONER/PHYSICIAN/ DOCTOR

Studen	nt Name:				
	Family Name		Given Name		Middle Name
Date of Birth:			Country of Birth:		
	Month	Day	Year		
IF THIS	FORM IS NOT COMPLETE	, YOU WILL NOT E	BE PERMITTED TO	PARTICIPATE IN TH	IE PROGRAM.
1.	MMR (Measles, Mu	ımps, Rubella)	Immunization	– Required	
	MMR Vaccination Da		 Day	Year	
	Measles Immunization		•	rear	
	Measies IIIIIIuiiizatioii	Month	Day	Year	
	Mumps Immunization [
		Month	Day	Year	
	Rubella Immunization D	Pate: Month	Day	Year	
2.	Mantoux Tuberculi	n Skin Test (TS	T) or Tuberculi	n Blood Test (T	BT) – Required
	A. Tuberculin Skin To	est (TST) Date: _	Month	Day	Year
	Result of Test:	Positive		-~1	
	B. Tuberculin Blood	Test (TBT) Date	: Month	Day	Year
	Result of Test:	Positive	Negative	·	

If TST or TBT results were Positive:										
Did Patient need to have a chest x-ray?YesNo										
Result of X-Ray:NormalAbnormal										
If TST or TBT results were Positive:										
Did Patient take Medication Treatment for TB?YesNo										
If yes, Drug Name:										
Dose and Frequency:										
	Month	Day	 Year							
Treatment End Date:		•								
		Day	Year							
A PHYSICAL EXAMINATION IS NOT REQUIRED – ALL INFORMATION MUST BE IN ENGLISH										
Name of Doctor/ Physician:										
Signature of Doctor/ Physician:										
Date:		 Day	Voor							
		•								
Address:										
Phone Number:										

Immunization Exemptions: A letter is required for religious exemption. Healthcare practitioner's note is requires for medical exemption.

PARTICIPANTS MUST EMAIL A COPY OF THIS FORM TO IEP@CSUSB.EDU BEFORE ARRIVING IN THE USA.

If this form is not completed participants will not be allowed to enter or observe in K-12 schools.