Medical Provider Form

Indiana University
Office of the Registrar
408 N. Union Street
Bloomington, IN 47405

Name ________________________________________________________________________________
(print)          Last              First            Middle

10-digit University ID Number ______________________              Date of Birth _____ / _____ / _____

All international students must complete section B.

SECTION A

Measles, Mumps, Rubella (MMR)

Students born after December 31, 1956:

This section must be completed by students who cannot provide immunization dates via the online
Immunization Compliance form due to one of the following:

1. You have immunity because you had the disease
2. You have laboratory evidence if immune titer
3. You are contraindicated to a vaccine

Each date provided requires medical documentation or a physician’s statement.

Measles (Rubeola)
1. Had disease (please attach documentation of physician diagnosis), OR _______ / _______
   month        year
2. Has laboratory evidence of immune titer (attach documentation), OR _______ / _______
   month        year
3. Contraindicated to vaccine; attach physician statement indicating
   type of contraindication (e.g., allergy to eggs, pregnancy, reaction
   to vaccine, etc.) and anticipated date of end of contraindication, OR _______ / _______
   month        year

Mumps
1. Had disease (please attach documentation of physician diagnosis), OR _______ / _______
   month        year
2. Has laboratory evidence of immune titer (attach documentation), OR _______ / _______
   month        year
3. Contraindicated to vaccine; attach physician statement indicating
   type of contraindication (e.g., allergy to eggs, pregnancy, reaction
   to vaccine, etc.) and anticipated date of end of contraindication. _______ / _______
   month        year

Rubella (German Measles)
1. Had disease (please attach documentation of physician diagnosis), OR _______ / _______
   month        year
2. Has laboratory evidence of immune titer (attach documentation), OR _______ / _______
   month        year
3. Contraindicated to vaccine; attach physician statement indicating
   type of contraindication (e.g., allergy to eggs, pregnancy, reaction
   to vaccine, etc.) and anticipated date of end of contraindication. _______ / _______
   month        year

SECTION B

Tuberculosis (TB) Testing

This section is REQUIRED to be completed by all international students. (It does not need to be completed by
US citizens or US permanent residents.)

Attach medical documentation that you have been tested for tuberculosis (TB) in the United States. The
documentation must include the date of the skin test or chest xray and the results of the test. Testing may be
scheduled at the IU Health Center once you arrive on campus.

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