University of Arkansas
RICH MOUNTAIN

IMMUNIZATION FORM

To ensure the health and safety of our campus, immunizations against communicable diseases is extremely important. Vaccination against Measles, Mumps, Rubella (MMR) and Tuberculosis (TB) is required of all students entering the University of Arkansas Rich Mountain. If you cannot provide a valid vaccination card/certificate, this form must be completed by a medical professional to prove your vaccination history. **If you have the vaccination card/certificate proving that you have taken the required vaccinations, there is no need to fill out this form.**

This form is specifically for MMR immunization. TB testing will and must be completed in the US after arrival. The TB testing will be coordinated by the Office of Athletics or the Office of Admissions. Please complete the form if not vaccine record is available and upload to your application account. Original copy of the form can be submitted in person upon arrival at UA Rich Mountain or by mail:

Office of Admissions
University of Arkansas Rich Mountain
1100 College Drive
Mena, Arkansas, 71953, USA

Student Information

_____
First Name Last Name

_____
Address

_____
Email address Phone

_____
Date of Birth (YYYY/MM/DD)

Required Immunization

The University of Arkansas Rich Mountain requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (MMR) prior to registration. One does must have been after 1980. The MMR vaccine is a 3-in-1 vaccine that protects against measles, mumps, and rubella:

1) It is recommended that the immunizations be completed before arriving to the United States. However, if delays prevent immunization completion, the procedures can be done at a local health clinic at the expenses of the student.

2) If immunization is not completed prior to admission, a hold will be placed on the student's record which will require them to complete the procedures before the next semester.

Measles, Mumps, and Rubella Vaccine

Date of first dose (YYYY/MM/DD)_____

Date of second dose (YYYY/MM/DD)_____

I certify that the above information are true.

_____

Signature of License Health Care Professional Date (YYYY/MM/DD) License number or office stamp