

Oregon law (ORS 433.283) requires that students born on or after January 1, 1957 involved in clinical experiences in allied health programs, practicum experiences in education and child care programs, and membership on intercollegiate sports teams have current immunizations for measles prior to each student's participation.

Students enrolling in clinical or practicum for dental assisting, nursing, nursing assistant, practical nursing, emergency medical services, human services, or early childhood education must complete this form and submit it to Rogue Central on any RCC campus. Students may also be required to provide documentation of measles immunizations. Check with individual department.

Form must be submitted before registering for clinical or practicum.

Name \_\_\_\_\_ Student ID \_\_\_\_\_

Address \_\_\_\_\_ Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Birthdate (mmddyyyy) \_\_\_\_\_

PROGRAM (check one)

<input type="checkbox"/>	Dental Assisting	<input type="checkbox"/>	Nursing
<input type="checkbox"/>	Early Childhood Education	<input type="checkbox"/>	Nursing Assistant
<input type="checkbox"/>	Emergency Medical Services	<input type="checkbox"/>	Practical Nursing
<input type="checkbox"/>	Human Services		

Immunization History (check one):

- I have had two doses of live measles vaccine after the age of 12 months, which were at least 30 days apart.  
Date of dose #1 \_\_\_\_\_ Date of dose #2 \_\_\_\_\_
- I do not have the date of my first dose, but my second dose was after December 1989  
Date of dose #2 \_\_\_\_\_

Student's signature \_\_\_\_\_ Date \_\_\_\_\_

EXEMPTIONS (Complete one of the following statements):

- AGE: My date of birth is prior to January 1, 1957; therefore I am exempt from the immunization requirements.

Student's signature \_\_\_\_\_ Date \_\_\_\_\_

- RELIGIOUS: I am adherent to a religion, the teachings of which are opposed to immunization, and I request that I therefore be exempt from this requirement. I understand that should an outbreak of measles occur, I may be excluded from activities that would expose me to possible disease.

Student's signature \_\_\_\_\_ Date \_\_\_\_\_

- MEDICAL:
  - Measles disease diagnosed by a physician. Date of disease \_\_\_\_\_
  - Measles Titer Date \_\_\_\_\_ Test Results \_\_\_\_\_
  - Valid medical contraindication. Indicate specific condition(s) \_\_\_\_\_

Signature of Physician or Health Dept. Representative \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Office Use Only

Date received \_\_\_\_\_ Received by \_\_\_\_\_

**Scan into student's record or send to Rogue Central for scanning**