



College of the Desert International Student Health Clearance

College of the Desert and the Intensive English Academy require all incoming international students to complete the attached Health Clearance form verifying vaccinations for Tuberculosis and Measles/Rubella.

We strongly recommend that you take care of these requirements BEFORE you enter the United States and bring the necessary documentation with you. If this is not possible, you will be able to take these tests in the United States. However, due to the high costs of these tests, (\$150 or more), it is advisable to consult your own medical doctor for assistance. *Students who complete the Health Clearance form in the United States will be required to pay for all costs associated with these tests.*

A completed International Student Health Clearance form must be on file before students will be allowed to register for classes. **Remember: You may not register for classes until you submit a completed International Student Health Clearance form.**

TB (Tuberculosis): All first time students entering College of the Desert/Intensive English Academy must provide proof of TB skin test or chest x-ray. Students coming directly from a foreign country must provide proof of the tuberculosis skin test (or chest x-ray) that was taken within 4 months of arrival into the United States. Students transferring from another US institution may use a TB skin test or chest x-ray if the results are less than 1 year old.

Measles (Rubeola) and Rubella: All first time students entering College of the Desert/Intensive English Academy are required to provide proof of immunization against measles (rubeola) and rubella. This applies to students who were born after January 1, 1957. Full immunization requires two (2) injections. This immunization can be waived if: 1) the student was born before 1957 OR 2) the student shows a lab result indicating immunity to both Rubella & Rubeola.

Directions: The attached form should be taken to your doctor to verify the above vaccinations/tests. Please ask your doctor to complete the required information and sign on BOTH the Tuberculosis and Measles (Rubeola) & Rubella sections.

You can either mail this document to the International Student Office, College of the Desert, 43-500 Monterey Avenue, Palm Desert, CA 92260 or bring it with you to our Orientation program. Again, this completed document will be required before students are allowed to register for classes.

The document will be kept in your permanent file in the International Student Office. All information is kept confidential and does not become part of your academic record.

Should you have any questions, please contact us at (760) 776-7205, fax (760) 862-1361 or cdelgado@collegeofthedesert.edu.

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Prior to registration, this form must be completed by your doctor and returned to the International Student Office. Please complete this form **BEFORE** you arrive in the United States. If the same physician conducts both tests, he/she must sign by each test as indicated. **Students cannot register for classes until the completed form has been submitted to the International Student Office.**

Name as it appears on your passport: _____
Family Name First Name

Date of Birth: _____ Email: _____
Month/Day/Year

Telephone: _____

1. Tuberculin Skin Test/TST (TST-Mantoux) Skin test:

(Test results must be within 4 months of the start date at College of the Desert)

Date of TST given: _____ (month/day/year)

Date of TST read: _____ (month/day/year)

Result of TST:

Negative: _____ (mm Induration)

Positive: _____ (mm Induration)

(If test is positive, a chest x-ray is required)

Chest X-Ray:

Date of Chest x-ray: _____ (month/day/year)

Results of Chest x-ray: Positive Negative

Physician's/Doctor's Signature

Physician's/Doctor's Name – Please Print

Street Address

Date

City

Zip Code

Telephone Number

State

Country

2. Mumps, Rubella & Measles immunization and/or titres is required:

MMR Immunizations:

1st injection: Date: _____ (month/day/year)

2nd injection: Date: _____ (month/day/year)

OR

Titre/Blood Test: Date: _____ (month/day/year)

Immunity

No immunity

Physician's/Doctor's Signature

Physician's/Doctor's Name – Please Print

Street Address

Date

City

Zip Code

Telephone Number

State

Country