



University of Nevada, Reno

Immunization Requirements for International Students

The following requirements must be met by all international students regardless of the length of their stay and must be completed **prior to** arrival at the University of Nevada, Reno.

The attached forms **must** be used to submit your immunizations.

Supporting documents **with dates and results** must also be submitted.

- **Tetanus/Diphtheria (Tdap/Td)**: One dose within the last 10 years. Tdap preferred over TD due to pertussis immunity.
- **Measles, Mumps, Rubella (MMR)**: Two doses, the first dose must be on or after your first birthday. If MMR vaccines are received before the first birthday, the student must receive another MMR vaccine. There must be at least 4 weeks between MMR dose #1 and MMR dose #2. If you have received two MMR vaccines but are unable to find your records, you can submit an MMR blood titer test.
- **Meningitis (MenACWY)**: One dose of Quadrivalent Meningitis occurring on or after age 16. Required for all students under the age of 23 at the time of enrollment. Meningitis Group B or C vaccines are not a requirement but recommended before coming to campus.
- **Tuberculosis (TB) Screening**: Complete Tuberculosis Screening Questionnaire. If you are born in a country with a high incidence of active TB or answer YES to any of the questions, you must complete one of the following TB screening tests within 6 months of enrollment:
 1. TB Blood Test – QuantiFERON, or
 2. TB Skin Test - PPD Mantoux
 - QuantiFERON testing is preferred, especially for students who have received BCG vaccines.
 - TB screening cannot be done within 4 weeks of a live vaccination but can be administered the same day as a live vaccine. (Ex. MMR, varicella)
 - A Chest Xray cannot be done in place of Tb Screening Tests.
 - If your TB test is POSITIVE, you must complete a Chest X-ray to rule out active Tuberculosis. Submit a copy of the X-ray report prior to traveling to the United States.
- **Physical**: Complete Physical Evaluation Clearance Form by a licensed Healthcare Provider. Students transferring from United States Universities do not need to complete.
- **US Date order is month/date/year.** Please document items in this format to avoid confusion



Name: _____ Date of Birth: / /

☐ YES ☐ NO Have you ever had contact with a person known or suspected to have active TB disease?

☐ YES ☐ NO Were you born in one of the countries or territories listed on the attached Appendix 2: 2025 High-Incidence Country List?
If yes, list country or territory: _____

☐ YES ☐ NO Have you resided in or traveled to one or more of the countries or territories listed on the attached Appendix 2: 2025 High-Incidence Country List for a cumulative period of one month or more?
If yes, list country or territory: _____

☐ YES ☐ NO Have you been a resident, volunteer and/or employee of a high-risk congregate settings such as a correctional facility, long-term care facility, or homeless shelters?

☐ YES ☐ NO Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

☐ YES ☐ NO Have you ever been a member of any of the following groups that may have an increased incidence of inactive TB infection or active TB disease: medically underserved, low-income, or using drugs or alcohol?

If the answer to all the above questions is NO, no further testing or further action is required.

Signature: _____ Date: ____/____/____

Appendix A: 2025 High-Incidence Country List

Countries with a three-year incidence ≥ 20 cases per 100,000 population, 2021-2023, n=129²⁴

Countries added in 2025: None; Countries subtracted in 2025: None.

- Afghanistan
- Algeria
- Angola
- Anguilla
- Argentina
- Armenia
- Azerbaijan
- Bangladesh
- Belarus
- Belize
- Benin
- Bhutan
- Bolivia (Plurinational State of)
- Bosnia and Herzegovina
- Botswana
- Brazil
- Brunei Darussalam
- Burkina Faso
- Burundi
- Cabo Verde
- Cambodia
- Cameroon
- Central African Republic
- Chad
- China
- China, Hong Kong SAR
- China, Macao SAR
- Colombia
- Comoros
- Congo
- Congo (Democratic Republic of)
- Cote d'Ivoire
- Djibouti
- Dominican Republic
- Ecuador
- El Salvador
- Equatorial Guinea
- Eritrea
- Eswatini
- Ethiopia
- Fiji
- Gabon
- Gambia
- Georgia
- Ghana
- Greenland
- Guam
- Guatemala
- Guinea
- Guinea-Bissau
- Guyana
- Haiti
- Honduras
- Haiti
- India
- Indonesia
- Iraq
- Kazakhstan
- Kenya
- Kiribati
- Korea (Democratic People's Republic of)
- Korea (Republic of)
- Kyrgyzstan
- Lao People's Democratic Republic
- Lesotho
- Liberia
- Libya
- Lithuania
- Madagascar
- Malawi
- Malaysia
- Maldives
- Mali
- Marshall Island
- Mauritania
- Mexico
- Micronesia (Federated States of)
- Moldova (Republic of)
- Mongolia
- Morocco
- Mozambique
- Myanmar
- Namibia
- Nauru
- Nepal
- Nicaragua
- Niger
- Nigeria
- Niue
- Northern Mariana Islands
- Pakistan
- Palau
- Panama
- Papua New Guinea
- Paraguay
- Peru
- Philippines
- Qatar
- Romania
- Russian Federation
- Rwanda
- Sao Tome and Principe
- Senegal
- Sierra Leone
- Singapore
- Solomon Islands
- Somalia
- South Africa
- South Sudan
- Sri Lanka
- Sudan
- Suriname
- Tajikistan
- Tanzania (United Republic of)
- Thailand
- Timor-Leste
- Togo
- Tunisia
- Turkmenistan
- Tuvalu
- Uganda
- Ukraine
- Uruguay
- Uzbekistan
- Vanuatu
- Venezuela (Bolivarian Republic of)
- Viet Nam
- Yemen
- Zambia
- Zimbabwe

Source: National Society of Tuberculosis Clinicians. *Testing and treatment of latent tuberculosis infection in the United States: clinical recommendations*. Smyrna, GA: National Tuberculosis Controllers Association, February 2021.



University of Nevada, Reno

International Student Immunization Form

*International Students must complete the following immunizations and/or tests before enrolling.
Supporting documentation with dates and results must be attached.*

Name: _____ Date of Birth: ____/____/____

Gender: _____ Country of Birth: _____

1. Tetanus/Diphtheria (Td/Tdap)

One dose within the last 10 years. Tdap preferred over TD due to pertussis immunity. Specify which vaccine was given.

Date: ____/____/____

2. *MMR (Measles, Mumps and Rubella)

Two vaccines needed; first one must have been received on or after the first birthday and second dose after age four.

MMR 1 Date: ____/____/____

MMR 2 Date: ____/____/____

OR

MMR blood titer (attach titer test result)

MMR Titer Date: ____/____/____

3. Meningitis Quadrivalent (MenACWY)

One dose of Quadrivalent Meningitis occurring on or after age 16. Required for all students under the age of 23 at the time of enrollment.

MenACWY Date: ____/____/____

4. Tuberculosis Testing - One of the following within 6 months of enrollment:

a. QuantiFERON (attach lab report)

Date: ____/____/____

Result: _____

b. PPD Skin Test

Date Placed: ____/____/____

Date Read: ____/____/____

Result: _____ mm

Provider signature: _____

Provider Name (print): _____

Date: ____/____/____

Office Stamp or Address:

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University of Nevada, Reno

Physical Evaluation Clearance Form for International Students

Name: _____ Date of Birth: ____/____/____

Gender: _____ Date of Exam: ____/____/____

HT: _____ WT: _____ BP: ____/____ HR: _____ Temp: _____

Vision: Right eye 20/____ Left eye 20/____ ☐ Corrected or ☐ Uncorrected

Allergies (list reactions): _____

Current medications: _____

Exam notes:

Skin	☐ Normal	☐ Abnormal: _____
Eyes	☐ Normal	☐ Abnormal: _____
Ears	☐ Normal	☐ Abnormal: _____
Mouth	☐ Normal	☐ Abnormal: _____
Neck	☐ Normal	☐ Abnormal: _____
Thyroid	☐ Normal	☐ Abnormal: _____
Lymph Nodes	☐ Normal	☐ Abnormal: _____
Thorax	☐ Normal	☐ Abnormal: _____
Lungs	☐ Normal	☐ Abnormal: _____
Heart	☐ Normal	☐ Abnormal: _____
Extremities:		
Pulses	☐ Normal	☐ Abnormal: _____
Radial	☐ Normal	☐ Abnormal: _____
Femoral	☐ Normal	☐ Abnormal: _____
Joints	☐ Normal	☐ Abnormal: _____
Edema	☐ Normal	☐ Abnormal: _____
Spine:	☐ Normal	☐ Abnormal: _____
Reflexes	☐ Normal	☐ Abnormal: _____

Clearance: ☐ **Granted** ☐ **Not Granted**

Is the student FREE of communicable disease?

☐ Yes ☐ No (please explain): _____

Does the student have any current physical, medical, psychological, or emotional health issues?

☐ No ☐ Yes (please explain): _____

Provider signature: _____

Provider Name (print): _____

Date: ____/____/____

Office Stamp or Address below