UAFS University of Arkansas - Fort Smith | Office of International Relations

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-Fort Smith. If you cannot provide a valid vaccination card/certificate, this form must be completed to prove your vaccination history. If you have the vaccination card/certificate proofing 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 has to be done in the US after arrival. Office of International Relations will coordinate the TB testing for all new international students.

Please complete the form and upload it to the online admission page. Original copy of the form MUST be submitted in person upon arrival at UAFS or by mail:

Office of International Relations
University of Arkansas – Fort Smith
5210 Grand Avenue, PO Box 3649,
Fort Smith, Arkansas, 72913-3649, USA

Student Information

____
First Name Last Name

____
Address

____
Email address

____
Phone

____
Date of Birth (YYYY/MM/DD)

REQUIRED IMMUNIZATION
The University of Arkansas Fort Smith requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (MMR) prior to registration. One dose must have been after 1980. The MMR vaccine is a 3-in-1 vaccine that protects against measles, mumps, and rubella.
a) 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 here in the U.S at a local health clinic at the expense of the student.
b) If immunization is not completed prior to admission, a hold will be placed on the students records which will require them to complete the procedures before the next semester.

Measles, Mumps, and Rubella Test

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