CHICAGO STATE UNIVERSITY

IMMUNIZATION HISTORY

			University Identification Number
Home Address			Preferred Phone ( ) / Alternate Phone ( )
City/State/Country/Zip or Postal Code			E-mail Address
Date of Birth (mm/dd/yyyy)	Age	Gender M ❑ F ❑ Other	Citizenship ❑ U.S. ❑ Other (specify)

Person to Notify in an Emergency Name:	Relationship	Contact Phone ( )
I hereby declare that all statements contained in this record are true and accurate and understand that false or inaccurate information is unlawful and a violation of the student code of conduct. **Signature:** **Date: / /**		Alternate Phone ( )

+ + + This section must be completed by a Licensed Health Care Provider. + + +

REQUIRED IMMUNIZATIONS (dates required include month/day/year)

■ **MEASLES-MUMPS-RUBELLA —** 2 doses -Measles, 2 doses-Rubella, and 2 doses-Mumps; **(MMR: Exempt if born before 1957)**

MMR (strongly recommended) 2 doses; second dose at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	**1** mm/dd/yy	***OR***	**MEASLES (Rubeola: Hard,Red, or Seven Day))** 2 doses; second dose at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1 mm/dd/yy
	2 mm/dd/yy			2 mm/dd/yy
Positive serum titers are also acceptable proof of immunity against measles, mumps and rubella. Lab report required and should be attached.			**MUMPS** 2 doses; second dose at least 28 days apart AND after 12 months of age	1 mm/dd/yy
				2 mm/dd/yy
Documentation of dates of disease **IS NOT** acceptable evidence of immunity against measles, mumps or rubella.			**RUBELLA(German or 3 day Measles)** 2 doses of Rubella All doses must be on or after 1st birthday; second dose at least 28 days apart.	1 mm/dd/yy
				2 mm/dd/yy

■ **TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DT, DTaP, Td, Tdap) — All students must show proof of any combination of 3 or more doses of Diphtheria, Tetanus, Pertussis, however only ONE must contain the Pertussis vaccine (Tdap). The last dost of vaccine (Td or Tdap) MUST be within 10 yrs of enrollment date. Tetanus Toxoid (TT) is NOT acceptable.**

1 (record first shot here) ❑ DTP/DTaP ❑ Tdap ❑ Td mm/dd/yy	2 ❑ DTP/DTaP ❑ Tdap ❑ Td mm/dd/yy	3 ❑ Tdap ❑ Td mm/dd/yy

■ **MENINGOCOCCAL CONJUGATE VACCINE -** Meningococcal meningitis is a potentially fatal, vaccine- preventable illness. The Meningococcal Conjugate Vaccine is **REQUIRED** for all students 21 and younger. A second vaccine **MUST** be given if the first vaccine was given before age 16.

❑ Menactra ❑ Menveo

1 mm/dd/yy

2 mm/dd/yy

RECOMMENDED IMMUNIZATIONS (complete if received)

HEPATITIS A	1 mm/dd/yy	2 mm/dd/yy	
HEPATITIS B Lab test providing immunity (attach report)	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
HPV (Gardasil) HPV (Cervarix)	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
VARICELLA Lab test providing immunity (attach report)	1 mm/dd/yy	2 mm/dd/yy	Date dx diagnosed and certified by physician mm/dd/yy

TUBERCULOSIS SCREENING							
1. Does the student have signs of active tuberculosis disease? ❑ Yes ❑ No							
2. Is the student a member of a high risk group or is student entering the health professions? ❑ Yes ❑ No							
3. Tuberculin Skin Test Date Given / / Date Read / / Results mm Positive _____Negative_____							
4. Chest x-ray(required if tuberculin skin test or IGRA is positive) result normal____ abnormal_____ Date of x-ray __ /___ / ___							
I. INTERFERON GAMMA RELEASE ASSAY (IGRA)					**J. CHEST X-RAY** (Required if TST or IGRA is positive)		
	Month	Day	Year	(specify method) QFT-G QFT-GIT other _____	Date of chest x- ray		
Result: ❑ Negative ❑ Positive ❑ Intermediate					Month	Day	Year
					Result: ❑ Normal ❑ Abnormal		
K. Influenza							
	Month	Day	Year		Month	Day	Year

Required Healthcare Provider Verification and Stamp Required		
HEALTH CARE PROVIDER (MD,DO,APN,NP,PA,RN,LPN,MA,PharmD) **VERIFY IMMUNIZATIONS WERE GIVEN**		
Provider Name (print)	Signature and credentials	Date
(Address including City/State/Country/Zip or Postal Code)		Phone

TO SUBMIT FORM to the Wellness/Health Center: Fax to (773) 995-2953 Phone (773) 995-2010

Or Mail to: Chicago State University Wellness/Health Center, 9501 S. King Drive ADM 131, Chicago, IL 60628

Submission Deadlines: **Fall – July 1, Spring - December 1, Summer - April 1**

COMPLIANCE NOTICE:

If you have not submitted your immunizations for compliance, an (I2) immunization registration hold and a $25.00 noncompliance fee will be assessed.

The immunization requirements are the following:

- Provide dates of any combination of three or more doses of Diphtheria, Tetanus, and Pertussis containing vaccine. One does must be a Tdap vaccine. The last dose of vaccine (DPT, DTaP, DT, Td, or Tdap) must have been received within 10 years prior to the term of enrollment.
- Show documentation of receipt of 2 doses of live Measles, Mumps, Rubella (MMR) vaccine. Students who cannot provide proof of immunization may provide laboratory (serologic) evidence of measles, mumps, rubella immunity.
- All new admissions under the age of 22, receipt of 1 dose of Meningococcal Conjugate vaccine on or after 16 years of age.
- **Resident hall students are required to obtain a physical and tuberculosis screening test within the last 12 months.**
- **INTERNATIONAL STUDENTS: ALL** documents **must** be in **ENGLISH** or **certified** translation**.** Contact the Chicago State University Wellness and Health Center to schedule your **required** Tuberculosis screening prior to receiving your campus housing assignment.

Contact the Chicago State University Wellness and Health Center for assistance obtaining any needed immunizations or laboratory (serologic) testing. Please call 773 995 2010 for an appointment.

Future registration and matriculation at Chicago State University will be in jeopardy for failure to comply.

Please be sure to make **two** copies. Bring one copy to the Wellness/Health Center and maintain one copy for your record.