➔*Attach a copy of your shot record* ***OR*** *if you do not have a copy of your shot record have a doctor or nurse fill out and sign this form.*

The Center for Health and Counseling Services
Mother Teresa Hall
(815) 836-5455

Student Immunization Information Form

Semester of FIRST Enrollment: Fall _______ (year) Spring _______ (year) Summer _______ (year)

Name: ____ Student ID#: ______________________
(last) (first) (MI)

Permanent Address: ____

Phone Number: (_____)____________________ Date of Birth: ______/______/______ Male ______ Female ______

ALL DATES MUST INCLUDE MONTH/DAY/YEAR

Td (Tetanus/Diphtheria)-1 booster dose of combined Td or Tdap within 10 years. Tetanus Toxoid (TT) is not acceptable.

1. ______/______/______ ***2.** ______/______/______ ***3.** ______/______/______

*International Students must provide documentation of a minimum of 3 doses (DPT/Td) with at least 1 dose within 10 years or must re-immunize.

MMR (measles, mumps and rubella)

Two doses required at least one month apart AND after 12 months of age AND after live vaccine available (5-1-71) **1.** _____/_____/_____ **2.** _____/_____/_____

IF MMR WAS NOT GIVEN, INDIVIDUAL IMMUNIZATION/IMMUNITY SHOULD BE LISTED BELOW

Measles (Rubeola, Hard, Red, 10 day)

1. Two doses required at least one month apart AND after 12 months of age AND after live vaccine available (1-1-68) **1.** _____/_____/_____ **2.** _____/_____/_____

OR 2. Date disease diagnosed and certified by physician. _____/_____/_____

OR 3. Lab test proving immunity. _____/_____/_____ **Attach lab report**

Mumps

1. One dose required after 12 months of age AND after live vaccine available (1-1-68) _____/_____/_____

OR 2. Date disease diagnosed and certified by physician _____/_____/_____

OR 3. Lab test proving immunity. _____/_____/_____ **Attach lab report**

Rubella (German measles, 3 day)

1. One dose required after 12 months of age AND after live vaccine available (1-1-70) _____/_____/_____

OR 2. Lab test proving immunity _____/_____/_____ **Attach lab report**

Health Care Provider's Signature (MD, DO, RN) verifying above information
OR record attached verifying information.

Name (print) ____________________________ Signature/title: _________________________ Date: ______________

Address: ____ Phone: ___________________________

Rev 06/10