



MEDICAL IMMUNIZATION FORM
University of Illinois at Chicago

FOR OFFICE USE ONLY	
<input type="checkbox"/> Complete	<input type="checkbox"/> Incomplete
<input type="checkbox"/> Updated	<input type="checkbox"/> File
<input type="checkbox"/> No data	RC _____

PART I: To be completed by the student. (Please Print)

_____/_____/_____
 Last Name First M.I. UIN Date of Birth

 Address (Number and Street) City and State Zip Code

(_____) _____ M F Sex Term of Admission (check only one) Fall (Aug.) Spring (Jan.) Summer (June) _____ Year
 Home Telephone Number

I authorize the University of Illinois at Chicago to release this immunization record to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Student's Signature _____ Date _____

Please read the instructions on the reverse side of this form before having it completed by a healthcare provider.

PART II: To be completed and signed by a healthcare provider.¹ All dates must include month, day, and year. (Check appropriate box.)

Students born before 1957 should see #7 on reverse side.

MEASLES (RUBEOLA)

- Immunization with live virus vaccine? (Two doses are required and must be given at least 30 days apart. Both doses given in 1968 or later, and given on or after first birthday.) Date 1 MM / DD / YY ___/___/___ Date 2 ___/___/___
- Disease confirmed by physician's records? Date of illness ___/___/___ Signature of physician _____
- Immunity confirmed by blood titer? Date of test ___/___/___ Attach copy of laboratory report
- Exemption? Attach physician's statement of medical contraindication with duration of medical condition

RUBELLA (GERMAN MEASLES)

- Immunization with live virus vaccine? (Given on 6/9/69 or later and given on or after first birthday.) Date ___/___/___
- Immunity confirmed by blood titer? Date of test ___/___/___ Attach copy of laboratory report
- Exemption? Attach physician's statement of medical contraindication with duration of medical condition

MUMPS

- Immunization with live virus vaccine? (Given on or after 12/28/67 and given on or after first birthday.) Date ___/___/___
- Disease confirmed by physician's records? Date of illness ___/___/___ Signature of physician _____
- Immunity confirmed by acceptable laboratory test? (See #6, reverse side.) Date of test ___/___/___ Attach copy of laboratory report
- Exemption? Attach physician's statement of medical contraindication with duration of medical condition

TETANUS and DIPHTHERIA (TD or DT or DPT)

Note: Tetanus Toxoid (TT) is not acceptable.

- Primary series completed? (At least three dose dates are required.) Date ___/___/___ Date ___/___/___ Date ___/___/___ If serious doubt exists about the completion of a primary three-dose series, two doses of combined (TD) toxoids should be given one month apart, followed by a third dose in 6 months.
- Most recent booster? (Must be within the last 10 years.) Date ___/___/___
- Exemption? Attach physician's statement of medical contraindication with duration of medical condition

PART III: To be completed and signed by a healthcare provider for health professions students ONLY.

College/School DENT AHS NURS PHARM POST GRAD PUBH* MED UIC Peoria Rockford Urbana-Champaign

- POLIO**
- Primary series completed? Date ___/___/___ Date ___/___/___ Date ___/___/___
 - Last booster? Date ___/___/___ Type: Oral (Sabin) Injection (Salk)
 - Immunized as adult? Date ___/___/___

TUBERCULOSIS

Tuberculin skin test (positive tine requires PPD)?

- Negative tine test this past year? Date ___/___/___
- Negative PPD (mantoux) test this past year? Date ___/___/___
- Positive PPD, chest x-ray required? Date of chest x-ray ___/___/___ Results of chest x-ray Positive Negative
- Had BCG vaccine? Date of vaccine ___/___/___ If had BCG, give PPD results:

¹Public health students are not required to submit documentation for polio. Students born before 1957 should see #7, reverse side.

Date of PPD ___/___/___ Results: Positive Negative
 If PPD is positive, complete #3 under Tuberculosis.

Health care provider verifying information for Part II and Part III.

Date _____

Name (Print) _____ Signature _____

Address _____ Telephone (_____) _____

¹Physician licensed to practice medicine in all of its branches (MD or DO), a local health authority, registered nurse employed by a school, college, or university, or a department-recognized vaccine provider.

INSTRUCTIONS FOR COMPLETION OF THE MEDICAL IMMUNIZATION FORM

OFFICE OF MEDICAL IMMUNIZATION RECORDS (MC 018)

University of Illinois at Chicago
Box 5220, Chicago, Illinois 60680-5220
(312) 413-0464

MUST BE COMPLETED AND RETURNED PRIOR TO THE STUDENT'S FIRST ENROLLMENT.

NOTE: Illinois law requires incoming new students to document immunity to measles, rubella, mumps, and tetanus/diphtheria.

PART I — To be completed by the student

All students who are admitted or readmitted to the University of Illinois at Chicago must submit this form. A healthcare provider (physician licensed to practice medicine in all of its branches [MD or DO]; a local health authority; registered nurse employed by a school, college, or university; or a department-recognized vaccine provider) must validate current immunization records in PART II. The completed form must be received by the Office of Medical Immunization Records at the University of Illinois at Chicago (envelope provided) no later than the first day of classes of the term. Failure to return this form and/or provide proof of immunity to the vaccine-preventable diseases may result in the student not being authorized to register for the next term.

(P.A. 85-1315)

The following are acceptable as documentation of immunization: (1) this form, (2) the Certificate of Child Health Examination form (high school record), and (3) a Certificate of Immunity showing the type of vaccine, date of each dose (month/day/year), the name of the physician or clinic that administered the vaccine, the phone number, and the address. ALL RECORDS must be verified or authenticated by a physician, registered nurse, or public health official and to be date- and dose-specific.

A student with a vaccine exemption may be excluded from the university/college in the event of a measles, rubella, mumps, or diphtheria outbreak in accordance with public health recommendations.

All records not in English must be accompanied by a certified translation.

Students are encouraged to keep a copy of this form for their personal health records. For additional information, the student may call the Office of Medical Immunization Records at (312) 413-0464.

PART II — Must be completed and signed by a healthcare provider¹

- All dates must include MONTH, DAY, and YEAR if it cannot otherwise be determined that the specific vaccine(s) was administered at the minimally acceptable age or dosage interval.
- All laboratory evidence of immunity must be accompanied by a copy of the laboratory report.
- All live virus vaccines must have been given on or after the first birthday.
- The minimum time between each dose of live measles virus vaccine must be at least 30 days.
- History of rubella disease is not acceptable as proof of immunity.
- Mumps titer is only acceptable as proof of immunity if the laboratory test used was a neutralization, enzyme-linked immunosorbent assay (ELISA or EIA) or radial hemolysis antibody test. A four-fold rise in antibody titer between appropriately spaced acute and convalescent sera is also acceptable.
- Individuals born prior to 1957 can be considered immune to measles, mumps, rubella, and polio. Such individuals are also exempt from the state law requiring immunization for tetanus/diphtheria. Health professions students born prior to 1957 are required to submit acceptable immunization documentation for tuberculosis.
- Only the following exemptions will be accepted and statements must accompany this record:
MEDICAL CONTRAINDICATIONS—A written, signed, and dated statement from a physician stating the specific vaccine or vaccines contraindicated and duration of medical condition that contraindicates the vaccine(s).
RELIGIOUS EXEMPTION—A written, signed, and dated statement by the student (or parent/guardian if the student is a minor) describing his/her objection to immunization on the grounds that they conflict with the tenet and practices of a recognized church or religious organization of which the student is an adherent or member.
PREGNANCY OR SUSPECTED PREGNANCY—A signed statement from a physician stating the student is pregnant or pregnancy is suspected and an approximate due date.
- International students may find it easier to be revaccinated than to obtain the necessary vaccination history.

PART III — To be completed by all students entering the health professions colleges. Proof of immunity for all diseases listed on this form must be provided prior to FIRST registration of health professions students (see Part II, #7).

Mail-in/Walk-in/Drop off	ETRM _____
No. _____	Coll _____
Date _____	Curr _____
Initials _____	A-Date _____
	Initials _____