Northeastern ILLINOIS UNIVERSITY

IMMUNIZATION FORM

The proof of immunization, certification of medical exemption or statement of religious objection must be received before Advance Registration begins for the semester immediately following the student's first semester of enrollment. Please submit to Student Health Services at 5500 North St. Louis Avenue Chicago, Illinois 60625-4699 - E 051 - (773) 442-5800.

PART 1 – TO BE COMPLETED BY STUDENT

Last Name	First	Middle Initial	If available: Student ID# _____ NEIU email: _____
Date of Birth (Mo/Day/Yr)	Phone		Term Attending (Check One) ☐ Fall ☐ Spring ☐ Summer Year _____
I authorize Northeastern Illinois University 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			International students must provide proof of Tuberculosis screening within one year of enrollment. Please call 773-442-5800 to schedule an appointment.

PART II - TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER** ALL DATES MUST INCLUDE MONTH, DAY & YEAR

Tetanus/Diphtheria/Pertussis

1. At least three doses; one must be Tdap — Date_____/_____/_____ (Month Day Year) Date_____/_____/_____ (Month Day Year) Date_____/_____/_____ (Month Day Year)
2. Most recent booster - (Must be within 10 years of enrollment date) — Date_____/_____/_____ (Month Day Year)
3. Exemption — Attach physician's statement of medical contraindication

Combined MMR (Measles, Mumps, Rubella) * — Date_____/_____/_____ (Month Day Year) Date_____/_____/_____ (Month Day Year) **OR**

Measles (Rubeola) * - Two required after first birthday. **1**

1. Immunization with live virus vaccine (if prior to 1968, proof of live vaccine without gamma globulin) — Date_____/_____/_____ (Dose 1) (Month Day Year) Date_____/_____/_____(Dose 2) (Month Day Year)
2. Immunity confirmed by blood titer: — Date of test _____Attach copy of laboratory report
3. Exemption — Attach physician's statement of medical contraindication

Mumps * - Two required after first birthday. **2**

1. Immunization with live virus vaccine — Date_____/_____/_____ (Month Day Year) Date_____/_____/_____ (Month Day Year)
2. Immunity confirmed by acceptable laboratory test — Date of test: _____ Attach copy of laboratory report
3. Exemption — Attach physician's statement of medical contraindication

Rubella (German Measles) * - Two required after first birthday **3**

1. Immunization with live virus vaccine — Date_____/_____/_____ (Month Day Year) Date_____/_____/_____ (Month Day Year)
2. Immunity confirmed by blood titer — Date of test: _____ Attach copy of laboratory report
3. Exemption — Attach physician's statement of medical contraindication

Meningitis - Required for all students age 21 or younger. Encouraged for all students, especially those in residence halls.

1. Meningococcal conjugate vaccine — Date_____/_____/_____ (Dose 1) (Month Day Year)
2. Second vaccine if first was given before age 16 — Date_____/_____/_____ (Dose 2) (Month Day Year)
3. Exemption — Attach physician's statement of medical contraindication

Part III - Recommended Immunizations

Hepatitis A: Date_____/_____/_____ Date_____/_____/_____ HPV: Date_____/_____/_____

Varicella: Date_____/_____/_____ Date_____/_____/_____ Date_____/_____/_____

Hepatitis B: Date_____/_____/_____ Date_____/_____/_____ Date_____/_____/_____ Date_____/_____/_____

Part IV - Health Care Provider or Official of the designated record keeping office verifying that above information is complete and accurate.

Physician**/Official Name:_____ Signature_____ Date: _____

Address:_____Contact # _____

* Proof of birth before 1/1/1957 can be used in lieu of proof of MMR immunity.

**Physican licensed to practice medicine in any of its branches (MD, DO), APN, a local health authority, registered nurse employed by a school, college or university, or a departmentally recognized vaccine provider.