**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 I – TO BE COMPLETED BY STUDENT

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle Initial</th>
<th>If available:</th>
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<tbody>
<tr>
<td></td>
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<td>Student ID# _______________________________</td>
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<td>NEIU email: ________________________________</td>
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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.

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______/______/______  
   Date______/______/______  
   Date______/______/______  

2. Most recent booster - (Must be within 10 years of enrollment date)  
   Date______/______/______

3. Exemption  
   -- Attach physician’s statement of medical contraindication

#### Combined MMR (Measles, Mumps, Rubella) *
- Two required after first birthday.  
  1. Immunization with live virus vaccine  
     (if prior to 1968, proof of live vaccine without gamma globulin)  
     Date______/______/______ (Dose 1)  
     Date______/______/______ (Dose 2)  
  2. Immunity confirmed by blood titer:  
  3. Exemption  
   -- Attach copy of laboratory report  
   -- Attach physician’s statement of medical contraindication

#### Mumps * - Two required after first birthday.
1. Immunization with live virus vaccine  
   Date______/______/______  
   Date______/______/______  
   Date______/______/______  

2. Immunity confirmed by acceptable laboratory test  
   Date of test _______________  
   -- Attach copy of laboratory report  
   -- Attach physician’s statement of medical contraindication

#### Rubella (German Measles) * - Two required after first birthday.
1. Immunization with live virus vaccine  
   Date______/______/______  
   Date______/______/______  
   Date______/______/______  

2. Immunity confirmed by blood titer  
   Date of test: _______________  
   -- Attach copy of laboratory report  
   -- 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)  

2. Second vaccine if first was given before age 16  
   Date______/______/______ (Dose 2)  

3. Exemption  
   -- Attach physician’s statement of medical contraindication

#### Part III - Recommended Immunizations

- Hepatitis A: Date______/______/______ Date______/______/______  
- Varicella: Date______/______/______ Date______/______/______  
- HPV: 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.

**Physician 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.