

KEEP A COPY FOR YOUR RECORDS.  
ORIGINALS WILL BE DESTROYED AFTER IMAGING.



**MEDICAL IMMUNIZATION FORM**

University of Illinois at Chicago  
Box 5220 Chicago, IL 60680-5220

FOR OFFICE USE ONLY  
 Complete  Incomplete  
 Updated  Duplicate  
RC \_\_\_\_\_

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

MM DD YYYY  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First M.I. University Identification Number (UIN) Date of Birth  
\_\_\_\_\_  
Address (Number and Street) City and State Zip Code

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

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.

MM DD YYYY  
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. All dates must include month, day, and year. (Check appropriate box.)  
Students born before 1957 should see #7 on reverse side.

**MEASLES (RUBEOLA)**  
1. 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ Date 2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
2. Disease confirmed by physician's records?  Date of illness \_\_\_\_/\_\_\_\_/\_\_\_\_  
3. Immunity confirmed by blood titer?  Date of test \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature of physician \_\_\_\_\_  
4. Exemption?  Attach physician's statement of medical contraindication with duration of medical condition or attach your personal statement of philosophical/religious objection to immunization Attach copy of laboratory report

**RUBELLA (GERMAN MEASLES)**  
1. Immunization with live virus vaccine? (Given on 6/9/69 or later and given on or after first birthday.)  Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
2. Immunity confirmed by blood titer?  Date of test \_\_\_\_/\_\_\_\_/\_\_\_\_ Attach copy of laboratory report  
3. Exemption?  Attach physician's statement of medical contraindication with duration of medical condition or attach your personal statement of philosophical/religious objection to immunization

**MUMPS**  
1. Immunization with live virus vaccine? (Given on or after 12/28/67 and given on or after first birthday.)  Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
2. Disease confirmed by physician's records?  Date of illness \_\_\_\_/\_\_\_\_/\_\_\_\_  
3. Immunity confirmed by acceptable laboratory test? (See #6, reverse side.)  Date of test \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature of physician \_\_\_\_\_  
4. Exemption?  Attach physician's statement of medical contraindication with duration of medical condition or attach your personal statement of philosophical/religious objection to immunization Attach copy of laboratory report

**TETANUS and DIPHTHERIA (TD or DT or DPT)**  
Note: Tetanus Toxoid (TT) is not acceptable.  
1. Primary series completed? (At least three dose dates are required.)  Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
2. Most recent booster? (Must be within the last 10 years.)  Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
3. Exemption?  Attach physician's statement of medical contraindication with duration of medical condition or attach your personal statement of philosophical/religious objection to immunization

MM DD YYYY  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Health care provider verifying information for Part II.  
Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_  
Address \_\_\_\_\_ Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

\*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.

# 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  
Telephone: (312) 413-0464  
Fax: (312) 355-4481

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. Include University Identification Number (UIN) on all documents.

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 should keep a copy of this form for their personal health records. All originals submitted to the Office of Immunization Records will be destroyed after imaging. For additional information, the student may call the Office of Medical Immunization Records at (312) 413-0464. Compliance can be viewed online at the Admissions web site under "Student Records."**

### **PART II** — Must be completed and signed by a healthcare provider<sup>1</sup>

1. 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.
2. All laboratory evidence of immunity must be accompanied by a copy of the laboratory report.
3. All live virus vaccines must have been given on or after the first birthday.
4. The minimum time between each dose of live measles virus vaccine must be at least 30 days.
5. History of rubella disease is not acceptable as proof of immunity.
6. 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.
7. 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.
8. 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).  
PHILOSOPHICAL OR 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.  
PREGNANCY OR SUSPECTED PREGNANCY—A signed statement from a physician stating the student is pregnant or pregnancy is suspected and an approximate due date.

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Mail-in/Walk-in/Drop off

No. \_\_\_\_\_

Date \_\_\_\_\_

Initials \_\_\_\_\_

ETRM \_\_\_\_\_

Coll \_\_\_\_\_

Curr \_\_\_\_\_

A-Date \_\_\_\_\_

Initials \_\_\_\_\_