DOMINICAN UNIVERSITY

IMMUNIZATION FORM

7900 W. Division, River Forest, Illinois 60305 PH: 708-524 6229 FAX 708-488-5072

MUST BE SUBMITTED BEFORE FIRST DAY OF CLASS IN COMPLIANCE WITH ILLINOIS LAW. LATE SUBMISSIONS WILL BE SUBJECT TO FINE

Part 1 – To be completed by student

Last Name (Please Print)	First	Middle Initial	If available: Student ID # _____ Dominican email: _____
Date of Birth (Mo/Day/Yr)	Sex M F	Phone Number(s)	Term Attending (Check One) ☐ Fall ☐ Winter ☐ Spring/Summer Year _____
I authorize Dominican 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			Last prior year in attendance at Dominican University? (former students only) _____ Were you born and educated grades 1 thru 12 in the United States? Yes ☐ No* ☐ (*See below*)

*All foreign-born students **must** show documentation of a **minimum** of **2** primary Tetanus AND a current TDAP.

Part II – To be completed and signed by health care provider * ALL DATES MUST INCLUDE MONTH, DAY & YEAR

Tetanus/Diphtheria

1. Primary Dates? (Should include at least two doses-- Indicate month, day and year) Date_____/_____/_____ (Month Day Year) Date_____/_____/_____ (Month Day Year)
2. Most recent booster (**Must be a *"TDAP"* within last 10 years**) 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)

Measles (Rubeola) – Two required after first birthday.

1. Immunization with live virus vaccine (Given in 1968 or later): Date_____/_____/_____ (Dose 1) (Month Day Year) Date_____/_____/_____(Dose 2) (Month Day Year)
2. Disease confirmed by physician's records — Date of Illness: _____Signature of Physician:_____
3. Immunity confirmed by blood titer: — Date of test _____Attach copy of laboratory report
4. Exemption — Attach physician's statement of medical contraindication

Rubella (German Measles) – Two required after first birthday Date_____/_____/_____ (Month Day Year) Date_____/_____/_____ (Month Day Year)

1. Immunization with live virus vaccine
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 Date_____/_____/_____ (Month Day Year) Date_____/_____/_____ (Month Day Year)

1. Immunization with live virus vaccine
2. Disease confirmed by physician's records — Date of Illness: _____Signature of Physician:_____
3. Immunity confirmed by acceptable laboratory test — Date of test: _____ Attach copy of laboratory report
4. Exemption — Attach physician's statement of medical contraindication

Menactra (Meningitis)

1. Immunization with live virus vaccine Date_____/_____/_____ (Dose 1) (Month Day Year) Date_____/_____/_____ (Dose 2) (Month Day Year)
2. Exemption — Attach physician's statement of medical contraindication

Part III- Recommended Immunizations

Hepatitis A: Date_____/_____/_____ Date_____/_____/_____ OR date of blood titer _____/_____/_____ **HPV:** Date_____/_____/_____

Varicella: Date_____/_____/_____ Date_____/_____/_____ OR date of blood titer _____/_____/_____ Date_____/_____/_____

Hepatitis B: Date_____/_____/_____ Date_____/_____/_____ OR date of blood titer _____/_____/_____ Date_____/_____/_____

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

Physician*/Official Name:_____ Signature_____ Date: _____

Address: _____Contact # _____

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

NOTE: Illinois law (TITLE 77 PART 694 COLLEGE IMMUNIZATION CODE **) requires incoming students taking 6 or more credit hours to document immunity to tetanus/diphtheria/pertussis, measles, rubella, mumps and menningitis.**

The following rules will apply:

1. All dates must include Month, Day and Year.
2. Part II Proof of immunity may be provided by a copy of the student's Certificate of Child Health Examination from an Illinois high school which provides the complete information necessary to assure compliance with the Act. The Certificate of Child Health Examination must be reviewed for compliance and attached to this form. Part III need not be completed.

RULES FOR ACCEPTABLE IMMUNIZATIONS AND BLOOD TESTS PROVING IMMUNITY:

3. Part III: must be completed and signed by a health care provider
   (Physician licensed to practice medicine in all of its branches (M.D. or D.O.), a local health authority, registered nurse employed by a school, college, or university, or a Department recognized vaccine provider)

   - All laboratory evidence of immunity must be accompanied by a copy of the laboratory report.
   - History of rubella disease is not acceptable as proof of immunity.
   - All live virus vaccines must have been given on or after the first birthday.
   - Mumps titer is only acceptable as proof of immunity if the laboratory 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.

RULES FOR EXEMPTIONS:

4. 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 or medical condition that contraindicated 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 estimated date of confinement.
   - Students enrolled only in programs designated by the University as "Online Only".

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

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

7. **A copy of immunizations must be sent to the Wellness Center. Individuals will be subject to fines each semester if not compliant with the requirements.**

WELLNESS CENTER
Dominican University, 7900 W. Division St. River Forest, IL 60305
Phone: 708-524-6229 Fax: 708-488-5072