

IMMUNIZATION RECORDS

Illinois Public Health Act 85-1315 requires that records be on file at Roosevelt University for all students (1) born on or after January 1, 1957 **AND** (2) enrolled for six or more credit hours per semester. The records need to be on file for reports to the State within the first term of enrollment.

Please submit your immunization records per the instructions below. If you cannot secure a copy of your records from your high school or a previously-attended college, you should see your physician as soon as possible to secure a copy, arrange to have the immunizations, or get the blood titer to show proof of immunization.

IMMUNIZATION RECORDS MUST BE ON FILE BEFORE A STUDENT CAN ATTEND CLASSES.

General Instructions and Information

Immunization Requirements FOR ALL STUDENTS

Type of Immunization	Records Should Show	If No Records Are Available
MEASLES (RUBEOLA)	Two doses MMR vaccine given after the 1st birthday and at	
MUMPS		
GERMAN MEASLES (RUBELLA)		

MANDATORY PHARMACY STUDENT IMMUNIZATION HISTORY

Please complete with your health care provider and return in the enclosed envelope before you arrive on campus. You may attach additional immunization information from other schools or medical offices. Responses must be in English.

MEASLES (RUBEOLA)

Immunity confirmed by Titer.

Results _____

Attach copy of lab report

Date of Titer _____

Date of re-immunization: _____

MUMPS

Immunity confirmed by Titer.

Results _____

Attach copy of lab report

Date of Titer _____

Date of re-immunization: _____

GERMAN MEASLES (RUBELLA)

Immunity confirmed by Titer.

Results _____

Attach copy of lab report

Date of Titer _____

Date of re-immunization: _____

TETANUS AND DIPHTHERIA

TD or DT or Tdap required (Tentanus toxoid (TT) not acceptable). Three primary series immunizations are needed OR date of last booster OR exempt status conferred. Please fill in the relevant portion below.

Immunization 1 - Date _____

Immunization 2 - Date _____

Immunization 3 - Date _____

OR

Last Booster Shot - Date _____ (Booster must be within last 10

years) OR

Exempt Status, Date of

TUBERCULOSIS (Check the appropriate box)

- HAS HAD THE DISEASE HAS NOT HAD THE DISEASE

AND fill out the appropriate section below for annual updates: NOTE: TUBERCULIN SKIN TEST (TST) 2 STEP MAY BE REQUIRED. TST READING MUST BE DONE FROM 48 HOURS AFTER APPLICATION.

- TST Step 1 Date read Result mm induration
TST Step 2 Date read Result mm induration

OR

- Had a positive Mantoux skin test. Year of skin test Attach documentation results and copy of chest x-ray report.
Baseline Chest X-Ray Date Positive Negative

- Had BCG vaccine. Date

OPTIONAL

- OTBG Quantiferon-Gold Blood Test

Date:

Result:

HEPATITIS B Three immunizations are needed AND the documentation of immunity by titer. Please fill in the relevant portion below.

- Immunization 1 - Date
Immunization 2 - Date
Immunization 3 - Date

AND

- Immunity confirmed by Titer. Date of Titer
HB surface antigen Positive Negative
HB surface antibody Positive Negative

Antibody must be positive. If the antibody titer is negative, the antigen is required. Repeat immunization may be required under certain circumstances. Attach copy of lab report.

VARICELLA ZOSTER (CHICKEN POX)

- Immunity confirmed by Titer. Date of Titer
Results Date of re-immunization:

Attach copy of lab report

CERTIFICATION BY HEALTH CARE PROFESSIONAL

Name (circle one) RN MD DO RPH

Name and address of institution or clinic (or stamp)

Phone FAX

I certify that this information is complete and correct to the best of my knowledge.

Signature of Health Care Provider Date