PROOF OF IMMUNIZATION

IMMUNIZATION RECORD

PLEASE COMPLETE AND RETURN TO:

Mail:
Roosevelt University
Office of Admission
1400 N. Roosevelt Blvd.
Schaumburg, IL 60173

Email:
admissionforms@roosevelt.edu

Fax:
847-619-8636

PART 1 – TO BE COMPLETED BY STUDENT (PLEASE PRINT)

Name: ____
Last *First* *Middle Initial*

Address: ____
Street *City* *State* *Zip*

Date of Birth (mm/dd/yyyy): ________________ **Sex:** [ ] Male [ ] Female **Student ID:** ________________

Home Phone: ________________ **Semester First Attending (Check One):** [ ] Spring [ ] Fall [ ] Summer, Year: 20___

I authorize Roosevelt University to release my immunization record to the Illinois Department of Public Health or its designated representative – for compliance audits in accordance with Illinois immunization law (Illinois Public Health Act 85-1315). This release also applies in the event of a health or safety emergency.

Student Signature: ______________________________________ **Date:** ________________

PART 2 – FOR COMPLIANCE THROUGH A CERTIFICATE OF CHILD HEALTH EXAMINATION

[ ] Check here if you are attaching a copy of a previously prepared certificate (generally issued as a result of elementary/high school requirements). You need NOT complete parts 3 and 4.

PART 3 – FOR COMPLIANCE THROUGH INFORMATION SUBMITTED AND SIGNED BY HEALTH CARE PROVIDER*

Part 3 need not be completed if you submit a copy of Certificate of the Child Health Examination. All dates must include month, day and year.

MEASLES (Rubeola)	Yes	Month, Day, Year	
1. Disease confirmed by physician records	[ ]	________ *Date of Illness*	________ *Signature of Physician*
2. Immunity confirmed blood titer	[ ]	________ *Date of Test*	Attach copy of a laboratory report.
3. First immunization with live attenuated virus must have been on or after the first birthday	[ ]	________ *Date of Immunization*	
4. Second immunization with live attenuated virus must have been given at least 28 days after first immunization	[ ]	________ *Date of Immunization*	
5. Exemption	[ ]	Attach Physician's Statement of Contraindication.	

* Physician licensed to practice medicine in all of its branches (M.D. or O.D.), Registered Nurse of a Public Health Official.

GERMAN MEASLES (Rubella)	Yes	Month, Day, Year	
1. Disease confirmed by blood titer	[ ]	________ *Date of Test*	Attach copy of a laboratory report.
2. Immunization with live attenuated virus	[ ]	________ *Date of Immunization*	
3. Exemption	[ ]	Attach Physician's Statement of Contraindication.	

(over)

MUMPS | Yes | Month, Day, Year

1. Disease confirmed by physician records or blood titer [ ] ________ *Date of Illness* ________ *Signature of Physician*

   [ ] ________ *Date of Test* — Attach copy of a laboratory report.

2. Immunization with live attenuated virus [ ] ________ *Date of Immunization*

3. Exemption [ ] Attach Physician's Statement of Contraindication.

TETANUS/DIPHTHERIA | Yes | Month, Day, Year

1. Primary series completed (must include at least two dates) [ ] ________ [ ] ________ [ ] ________ [ ] ________

2. Most recent booster (must be within last 10 years) [ ] ________

3. Exemption [ ] Attach Physician's Statement of Contraindication.

MENINGITIS | Yes | Month, Day, Year

1. Immunization 1 (Menactra or Menveo required if 21 years of age or younger) [ ] ________

2. Immunization 2 (if 1st vaccine was given before age 16) [ ] ________

COVID-19 | Month, Day, Year

1. First immunization - REQUIRED (circle one) Moderna - Pfizer - J&J/Janssen Novavax - Other________ ________ *Date of Immunization*

2. Second immunization - REQUIRED (circle one) Moderna - Pfizer - J&J/Janssen Novavax - Other________ ________ *Date of Immunization*

3. Booster dose(s) - *Recommended but not required*
   List vaccine brand ________________
   List vaccine brand ________________
   List vaccine brand ________________

4. Evidence of Vaccination (upload documentation from health care provider, state vaccine registry, or copy of COVID-19 Vaccine Card)

5. Exemption Request with Supporting Documentation

PART 4 – HEALTH CARE PROVIDER OR ADMINISTRATOR VERIFYING PART 3 INFORMATION*

Name (print): ________________ **Signature:** ________________

Phone: ________________ **Date:** ________________

* Physician licensed to practice medicine in all of its branches (M.D. or O.D.), Registered Nurse of a Public Health Official.

FOR ROOSEVELT USE ONLY

Reviewed by: ________________ [ ] **Incomplete Date:** ________________ [ ] **Complete Date:** ________________

		Measles (Rubeola)	German Measles (Rubella)	Mumps	Tetanus/ Diphtheria	Meningitis	COVID-19
Immune:		[ ]1st [ ]2nd	[ ]	[ ]	[ ]	[ ]1st [ ]2nd	[ ]1st [ ]2nd
Exempt:	Medical or Religious	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
	External Studies or One Course	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
	Pregnancy (temporary exemption)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
	Susceptibility List	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]