MEASLES (Rubeola)

1. Disease confirmed by physician records [ ]
2. Immunity confirmed blood titer [ ]
3. First immunization with live attenuated virus must have been on or after the first birthday [ ]
4. Second immunization with live attenuated virus must have been given at least 28 days after first immunization [ ]
5. Exemption [ ]

GERMAN MEASLES (Rubella)

1. Disease confirmed by blood titer [ ]
2. Immunization with live attenuated virus [ ]
3. Exemption [ ]

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 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.

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

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

2. Immunization with live attenuated virus [ ]

3. Exemption [ ]

**TETANUS/DIPHTHERIA**

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

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

3. Exemption [ ]

**MENINGITIS**

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**

1. First immunization - REQUIRED (circle one)
   Modena - Pfizer - J&J/Janssen
   Novavax - Other __________ [ ] Date of Immunization

2. Second immunization - REQUIRED (circle one)
   Modena - Pfizer - J&J/Janssen
   Novavax - Other __________

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

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**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.

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**FOR ROOSEVELT USE ONLY**

Reviewed by: ___________________________ [ ] Incomplete Date: ___________________________ [ ] Complete Date: ___________________________

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