

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	<input type="checkbox"/>	<div><div>_____</div><div><i>Date of Illness</i></div></div> <div><div>_____</div><div><i>Signature of Physician</i></div></div>
2. Immunity confirmed blood titer	<input type="checkbox"/>	<div><div>_____</div><div><i>Date of Test</i></div></div> <div><div>_____</div><div><i>Attach copy of a laboratory report.</i></div></div>
3. First immunization with live attenuated virus must have been on or after the first birthday	<input type="checkbox"/>	<div><div>_____</div><div><i>Date of Immunization</i></div></div>
4. Second immunization with live attenuated virus must have been given at least 28 days after first immunization	<input type="checkbox"/>	<div><div>_____</div><div><i>Date of Immunization</i></div></div>
5. Exemption	<input type="checkbox"/>	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	<input type="checkbox"/>	<div><div>_____</div><div><i>Date of Test</i></div></div> <div><div>_____</div><div><i>Attach copy of a laboratory report.</i></div></div>
2. Immunization with live attenuated virus	<input type="checkbox"/>	<div><div>_____</div><div><i>Date of Immunization</i></div></div>
3. Exemption	<input type="checkbox"/>	Attach Physician's Statement of Contraindication.

(over)

MUMPS	Yes	Month, Day, Year	
1. Disease confirmed by physician records or blood titer	[]	_____	_____
	[]	_____	_____
2. Immunization with live attenuated virus	[]	_____	_____
3. Exemption	[]	_____	

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	[]	_____	

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)	[]	_____	

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 or a Public Health Official.

FOR ROOSEVELT USE ONLY

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

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