



## 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	[ ]	_____	_____ <i>Date of Illness Signature of Physician</i>
2. Immunity confirmed blood titer	[ ]	_____	_____ <i>Date of Test Attach copy of a laboratory report.</i>
3. First immunization with live attenuated virus must have been on or after the first birthday	[ ]	_____	_____ <i>Date of Immunization</i>
4. Second immunization with live attenuated virus must have been given at least 28 days after first immunization	[ ]	_____	_____ <i>Date of Immunization</i>
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 or a Public Health Official.

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

<b>MUMPS</b>	Yes	Month, Day, Year	
1. Disease confirmed by physician records or blood titer	[ ]	_____	<i>Signature of Physician</i>
	[ ]	<i>Date of Illness</i>	
		_____	Attach copy of a laboratory report.
		<i>Date of Test</i>	
2. Immunization with live attenuated virus	[ ]	_____	
		<i>Date of Immunization</i>	
3. Exemption	[ ]		Attach Physician's Statement of Contraindication.

<b>TETANUS/DIPHTHERIA</b>	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.

<b>MENINGITIS</b>	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	[ ]	[ ]	[ ]	[ ]	[ ]