

Student's Name _____

Social Security Number _____

Date of Birth _____

**LOYOLA UNIVERSITY CHICAGO
MARCELLA NIEHOFF SCHOOL OF NURSING**

Clinical Course Health Requirements

University requirements include Polio immunization history and TB screen results. Particular school requirements are identified below. Requirements are to be met PRIOR TO MATRICULATION. The following rules apply:

1. All dates must include Month, Day, and Year.
2. Proof of immunity may be provided by a copy of the Certificate of Child Health Examination, if the information is complete and assures compliance with the State of Illinois Immunization act. Sign and date the form in the space provided below.
3. Records must be completed and signed by a health care provider, i.e., a physician licensed to practice medicine in all its branches, M.D. or D.O. or registered nurse or a public health official.
4. All laboratory evidence of immunity must be accompanied by a copy of the lab report.
5. History of disease is NOT acceptable proof of immunity to Measles. CDC recommend two doses for this age-group. If immune globulin was given from 1963 to 1975, revaccinate with 2 doses at least one month apart.
6. All live vaccines must have been given after 1968 on or after first birthday, preferably at 15 months and after.
7. Only the following exemptions will be accepted and statements must accompany this record
 - Medical contraindications: A written, signed, and dated statement from a physician citing the vaccine(s) contraindicated and duration or medical condition that contraindicates the vaccine(s).
 - Religious Exemption: by the student (or parent/guardian, if a minor), describing the objection to immunization based upon bona fide religious tenets or practice
 - Pregnancy or suspected pregnancy: a signed statement stating that the student is pregnant or pregnancy is suspected and length of exemption.
8. Anyone with a vaccine exemption may be excluded from the University in the event of outbreak.
9. All records not in English must be accompanied by a certified translation.
10. If no records are available, the State of Illinois recommends re-immunization unless exempted under item no. 7.
11. International and nursing students must provide evidence of at least two doses of the primary series and date of booster within 10 years of the term of enrollment. Domestic students need only evidence of the date of the booster within 10 years of enrollment.

VACCINATION RECORD

A. Measles (Rubeola) Date: 1) _____ 2) _____ or Titer Result+ _____

B. Mumps (Parotitis) Date: 1) _____ or Disease confirmed Date: _____ or Titer Result+ _____
by physician record

C. MMR Date: 1) _____ 2) _____ 3) _____

D. German Measles (Rubella) Immunization Date: _____ Titer Result+ REQUIRED: PLEASE ATTACH COPY OF REPORT

E. Chicken Pox (Varicella) Titer Result+ REQUIRED: PLEASE ATTACH COPY OF REPORT

F. Diphtheria/Tetanus Primary Series DTPORTID
1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
Booster within 10 years of enrollment

G. Polio* Immunization or History of Disease
1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ Booster: ___/___/___

*If no immunization dates available, IPV Booster is needed

H. Hepatitis B History of Disease Type of Vaccine Administered _____ Booster
Dates: ___/___/___ ___/___/___ ___/___/___ ___/___/___

I. TB Screen (2-step) History of Disease PPD Result
1. ___/___/___ 2. ___/___/___ Result: 1. _____ 2. _____

J. CXR Date: _____ PLEASE ATTACH COPY OF CXR Result

Health care provider verifying above information: _____

Print Name: _____ Telephone: (_____) _____

Address: _____ City, State and Zip Code: _____

Signature: _____ Date: _____

PLEASE RETURN THIS FORM TO: WELLNESS CENTER

Loyola University Chicago
1144 Loyola Avenue, Campion Hall, Lower Lever, Chicago, Illinois 60626

