

## REQUIRED IMMUNIZATION INFORMATION FORM

(See instructions on reverse side)

Semester of FIRST Enrollment: Fall \_\_\_\_\_(year) Spring \_\_\_\_\_(year) Summer \_\_\_\_\_(year)

Have you attended LUC previously? No  Yes  If yes, what year? \_\_\_\_\_

Name: \_\_\_\_\_ LUC ID # \_\_\_\_\_  
(last) (first) (middle)

Permanent Address: \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female   
month/day/year

**ALL DATES MUST INCLUDE MONTH/DAY/YEAR**

**MMR (measles, mumps, rubella)**

Two doses required, at least one month apart, AND after #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 12 months of age AND after live vaccine available (5-1-71) month/day/year month/day/year

**IF MMR WAS NOT GIVEN, INDIVIDUAL IMMUNIZATIONS SHOULD BE LISTED BELOW**

**Measles (Rubeola, Hard, Red, 10 day)**

- 1. Two doses required, at least one month apart, after 12 months of age AND after live vaccine available. (1-1-68) #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year month/day/year
- OR 2. Date disease diagnosed and certified by physician \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year
- OR 3. Lab test proving immunity \_\_\_\_/\_\_\_\_/\_\_\_\_ **attach lab report**
- OR 4. Born before 1957 – see other side \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year

**Rubella (German measles, 3 day)**

- 1. One dose required, after 12 months of age, AND after live vaccine available. (6-19-69) \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year
  - OR 2. Lab test proving immunity \_\_\_\_/\_\_\_\_/\_\_\_\_ **attach lab report**
  - OR 3. Born before 1957 – see other side. \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year
- Is female able to get pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

**Mumps**

- 1. One dose required, after 12 months of age, AND after live vaccine available. (1-1-68) \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year
- OR 2. Date disease diagnosed and certified by physician \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year
- OR 3. Lab test proving immunity \_\_\_\_/\_\_\_\_/\_\_\_\_ **attach lab report**
- OR 4. Born before 1957 – see other side \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year

**Td (tetanus/diphtheria) Domestic Students**

Must be within ten years of the first day of the first semester. \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year

**International students**

Must have a series of three tetanus shots. One shot must be within 10 years.

\_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year month/day/year month/day/year

**Health Care Provider's Signature (MD, DO, RN) verifying above information  
 OR records attached verifying information.**

Name(print) \_\_\_\_\_ Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**INTERNATIONAL STUDENTS ONLY**

Tuberculosis skin testing is mandatory and must be done in the United States. If you have been treated for Tuberculosis please bring your English translated medical records. If you were diagnosed with a positive reaction to tuberculosis documentation is required. TB testing is available at the Wellness Center for a small fee.

## IMMUNIZATION INFORMATION INSTRUCTIONS

- In accordance with state legislation and actions of the Illinois Department of Public Health, Loyola University Chicago requires that this document be **completed and returned one month prior to the first day of the semester in which a student is first enrolled**. This requirement applies to all newly admitted students, including new graduate students, readmitted students, and transfer students.
- STUDENTS MUST SHOW PROOF OF IMMUNIZATIONS. HAVE A HEALTH CARE PROVIDER COMPLETE THIS FORM OR SEEK IMMUNIZATION RECORDS FROM PERSONAL PHYSICIAN OR THE MEDICAL RECORD PORTION OF HIGH SCHOOL TRANSCRIPT, OR MILITARY RECORDS.
- If completed by Physician/Health Care Provider, signature verifying information is required.
- **ALL DATES MUST INCLUDE MONTH/DAY/YEAR.**
- **All records not in English must be accompanied by a certified translation**
- **EXEMPTIONS:**
  - **Medical exemptions must include physician's letter of explanation and date exemption ends.**
  - Males are considered immune to measles, mumps, and rubella if born before 1957. Females are immune to measles and mumps if born before 1957. However, to be considered immune to rubella, females must be born before 1957 with no potential for pregnancy. Documentation required. One dose of tetanus/diphtheria within the last ten years is required for all age groups.
- KEEP A COPY of this form for your personal health records or in the event it is not received by the Wellness Center. For additional immunization information, call the Wellness Center (773) 508-2530.
- **MAIL COMPLETED IMMUNIZATION INFORMATION FORM AND HEALTH HISTORY FORM TO:**

**Wellness Center**  
**1144 Loyola Avenue**  
**Chicago, Illinois 60626**
- **FAX (773) 508-2505**

**NOTE: Incomplete immunization information will **BLOCK** access to registering **OR** changing classes**

### REQUEST FOR ADDITIONAL INFORMATION

**THE FOLLOWING ARE NOT REQUIRED (NO health care provider signature required)**

**Hepatitis B** vaccine is highly recommended. #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
If you have had this series, please fill in dates: #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Varivax** (varicella vaccine) is also highly recommended if you have not had chickenpox.  had disease OR vaccine:  
#1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Meningitis/meningococcal** disease/(menomune vaccine) Menomune vaccine \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Meningococcal meningitis is an infection of the brain and its covering layers. It may cause death or permanent disability. College freshmen, especially those who live in residence halls, are at modestly increased risk for this infection. This form of meningitis is passed from person to person by close contact. There is an immunization available that affords substantial protection against this disease. For more information about this disease or vaccine, please visit our web site: <http://www.luc.edu/wellness/> or call Wellness Center (773) 508-2530. Meningitis and Hepatitis vaccines are available through the Wellness Center and may be subject to additional charge.

### AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS

To be completed by a Parent or Guardian if the student will be under the age of 18 prior to establishing residency in the community.

I, the parent/legal guardian of (PRINT STUDENT NAME) \_\_\_\_\_, in consideration of the services rendered and of the facilities provided by Loyola University Chicago Wellness Center, hereby voluntarily, and knowingly authorize and give my expressed consent to hospitalization, a visit or visits when either unaccompanied or accompanied by myself or another adult while in transit to, from, or in attendance at Loyola University Chicago, for the purpose of clinical observations, and/or the administration of such treatment, and the taking of whatever x-rays, injections, or drugs that may be considered necessary or desirable in the observation, diagnoses, and treatment of his/her case by the physician in attendance and/or the staff of Loyola University Chicago Wellness Center.

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date

### PRIVACY RIGHTS WAIVER (optional)

I give my consent to allow this form to be viewed by officials of the Illinois Department of Public Health as part of their compliance audit of the university.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date