Loyola University Chicago

LOCUS TRAINING

Entering Immunizations in LOCUS

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Entering Immunizations through the Student Center in LOCUS

1.) In the Student Center, click Immunizations.
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.

Missing or incomplete immunization information will BLOCK access to registering OR changing courses.

INSTRUCTIONS:
Complete this online form AND provide verification of these immunization dates by submitting one (or a combination) of the following:
- signed copy of the LUC required immunization form www.luc.edu/wellness.
- records from previous school.
- records from a public health agency.
- records from a health care provider

Note: If you are requesting a religious or medical exemption or have other questions, contact the Wellness Center at 773 508-2530.

The Wellness Center FAX number is 773-508-2505

<table>
<thead>
<tr>
<th>Immunization Abbreviation</th>
<th>Trade Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap (Tetanus, Diphtheria, Pertussis)</td>
<td>Adacel, Boostrix</td>
</tr>
<tr>
<td>Td (Tetanus, Diptheria)</td>
<td>Decavac</td>
</tr>
<tr>
<td>HepB (Hepatitis B)</td>
<td>Energix-B, Recombivax HB</td>
</tr>
<tr>
<td>VAR (Varicella)</td>
<td>Varivax</td>
</tr>
<tr>
<td>MCV4 (Meningitis)</td>
<td>Menactra, Menceo</td>
</tr>
<tr>
<td>TIV (Trivalent inactivated influenza vaccine)</td>
<td>Afluria, Agriflu, Fluarix, FluLaval, Fluvirin, Fluzone</td>
</tr>
</tbody>
</table>
2.) Click “enter.”

3.) Enter your latest “Booster Date.”

4.) Select the Type of Tetanus Immunization. (If the T/D type is unknown, enter T/D.)

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**Immunization Detail**

**Mozart, Wolfgang Amadeus**

**Immunization/Test Name:** Tetanus/Diphtheria

**Latest Booster**

**Booster Date:**

**Type of Tetanus Immunization**

**Primary Shots**

**Type of Tetanus Immunization**

**Primary 1 Date:**

**Primary 2 Date:**

**Primary 3 Date:**

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**Domestic Students:**
Must be within the past 10 years.

**International Students:**
Must have a series of 3 tetanus shots. One shot must be within the past 10 years.

**Note:** If T/D type is unknown, use T/D
**MMR (measles, mumps, rubella)**

Two doses required, at least one month apart, AND after 12 months of age AND after live vaccine available (5-1-71)  

If MMR was not given, individual immunizations should be listed below.

<table>
<thead>
<tr>
<th>Task</th>
<th>Date 1</th>
<th>Date 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles (Rubella) 1. Two doses required, after 12 months of age,</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>OR 2. Date disease diagnosed and certified by physician</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>OR 3. Lab test proving immunity</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>OR 4. Born before 1957 – see other side</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

**Rubella (German measles)**

1. One dose required, after 12 months of age, AND after live vaccine available (6-19-69)

OR 2. Lab test proving immunity

OR 3. Born before 1957 – see other side.

**Mumps**

1. One dose required, after 12 months of age, AND after live vaccine available (1-1-68)

OR 2. Date disease diagnosed and certified by physician

OR 3. Lab test proving immunity

OR 4. Born before 1957 – see other side.

**Td (tetanus/diphtheria) or Tdap (tetanus/diphtheria/pertussis), Domestic Students**

Must be within 10 years of the first day of the first semester.

**International Students**

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

**Health Care Provider’s Signature (MD, DO, RN) verifying above information**

Name (print) ____________________________  Signature/Title ____________________________  Date ____________

**Immunization Detail**

Mozart, Wolfgang Amadeus

Immunization/Test Name: Tetanus/Diphtheria

**Latest Booster**

| Booster Date: | 01/22/2009 | T/D | T tetanus/Diphtheria |

**Primary Shots**

| Primary 1 Date: | 11 |   |
| Primary 2 Date: | 11 |   |
| Primary 3 Date: | 11 |   |

5.) Click “OK.”

Domestic Students: Must be within the past 10 years.

International Students: Must have a series of 3 tetanus shots. One shot must be within the past 10 years.

Note: If T/D type is unknown, use T/D
6.) Select how you are sending your documents.

7.) Click “Save & Submit for Verification.”

8.) Click “OK.”

You can see that your records have been Submitted for Verification.

After your records have been verified, a green checkmark (✔️) means that your documents have been verified and accepted and a red circle with a white x (❌) indicates that your records are not compliant.
### Working with Titers

**Immunization Detail**

<table>
<thead>
<tr>
<th>Measles, Mumps and Rubella Combination (MMR)</th>
<th>Measles Only (Rabies)</th>
<th>Mumps Only</th>
<th>Rubella Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dose(s)</strong></td>
<td><strong>Dose(s)</strong></td>
<td><strong>Dose(s)</strong></td>
<td><strong>Dose(s)</strong></td>
</tr>
<tr>
<td>Dose 1:</td>
<td>Dose 1 Date:</td>
<td>Dose 1 Date:</td>
<td>Dose 1 Date:</td>
</tr>
<tr>
<td>Dose 2:</td>
<td>Dose 2 Date:</td>
<td>Dose 2 Date:</td>
<td>Dose 2 Date:</td>
</tr>
</tbody>
</table>

Two MMR doses required, at least one month apart, after 12 months of age. If MMR not given, individual measles, mumps and rubella should be entered.

To enter a Titer, click “Titer Results Sent” and then click “OK.”

If your titer results returned a negative result, you must enter a booster date and resubmit.
Printing your Immunization Documents

1.) Click “Printable Document.”

2.) View, save, or print your PDF.

NOTE: Only verified immunizations/health tests will be printed.

Please refer to Wellness Center Website for Immunization Record Requirements.
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 # if known __________

(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 ______/____/____
12 months of age AND after live vaccine available (5-1-71) ______/____/____

If MMR was not given, individual immunizations should be listed below

Measles (Rubeola)
1. Two doses required, at least one month apart, after 12 ______/____/____
   months of age AND after live vaccine available (1-1-68) ______/____/____
   OR 2. Date disease diagnosed and certified by physician ______/____/____
   OR 3. Lab test proving immunity ______/____/____
   OR 4. Born before 1957 – see other side ______/____/____

Rubella (German measles)
1. One dose required, after 12 months of age, ______/____/____
   AND after live vaccine available. (6-19-69) ______/____/____
   OR 2. Lab test proving immunity ______/____/____
   OR 3. Born before 1957 – see other side ______/____/____

Mumps
1. One dose required, after 12 months of age, ______/____/____
   AND after live vaccine available. (1-1-68) ______/____/____
   OR 2. Date disease diagnosed and certified by physician ______/____/____
   OR 3. Lab test proving immunity ______/____/____
   OR 4. Born before 1957 – see other side ______/____/____

Td (tetanus/diphtheria) or Tdap (tetanus/diphtheria/pertussis), Domestic Students
Must be within ten years of the first day of the first semester ______/____/____

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 signed 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.
Required 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.

- **Your health care provider should complete and sign this form.** Or you may submit immunization records signed by a healthcare provider from your personal physician, your high school transcript, or military records. State issued records are also accepted. Records must include a healthcare provider signature.

- **All dates must include month/day/year.**

- **All records not in English must be accompanied by a certified translation.**

- Keep a copy of this form for your records or in the event it is not received by the Wellness Center. For additional immunization information, call the Wellness Center (773) 508-2530 or go to www.luc.edu/wellness.

- Mail or fax your completed immunization form and health history form to:

  Wellness Center  
  1052 Loyola Avenue  
  Chicago, Illinois 60626  
  FAX (773) 508-2505

**Note:** Missing or incomplete immunization information will BLOCK access to registering OR changing classes

- **Exemptions:** For more information call the Wellness Center at (773) 508-2530
  - 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.

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**Request For Additional Information**

The following are not required but are recommended:

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

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

- **Meningococcal 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/](http://www.luc.edu/wellness/) or call Wellness Center (773) 508-2530. Limited quantities of Meningitis and Hepatitis vaccines are available through the Wellness Center for an additional charge. Going to your personal physician may decrease your cost.

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**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 when beginning school.

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 staff of Loyola University Chicago Wellness Center.

Signature of parent/legal guardian __________________________ Date ______

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**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 ______

Rev.06.2007 DA