Student Immunization Record

Last Name First Name Middle Name

Address_____

Street City State Zip

Phone Number ____-____-____ Date of Entry _____ Date of Birth _____ Student ID# _____

Status Male ☐ Female ☐ Part-time ☐ Full-time ☐ Graduate ☐ Undergraduate ☐ Professional ☐

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. All information must be in English.

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)
1. Dose 1 given at age 12-15 months or later..... #1 ____/____/____
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose..... #2 ____/____/____

B. TETANUS-DIPHTHERIA (Primary series with DTaP or DTP and booster with Td/Tdap in the last ten years meets requirement. Refer to ACIP for details.)
1. Primary series of four doses with DTaP or DTP:
   #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____
2. Tetanus-Diphtheria (Td/Tdap) booster within the last ten years ..... ____/____/____

C. VARICELLA (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized at the age of 13 or older meets the requirement.)
1. History of Disease Yes ☐ No ☐
2. Varicella Antibody ____/____/____ Reactive _____ Non-reactive _____
3. Immunization
   a. Dose #1 ..... #1 ____/____/____
   a. Dose #2, given at least one month after first dose, if age 13 years or older ..... #1 ____/____/____

D. HEPATITIS B (Three doses of a vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody meets the requirement.)
1. Immunization (Hepatitis B)
   a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____
2. Hepatitis B Surface antibody Date ____/____/____ Result: Reactive _____ Non-reactive _____

E. HEPATITIS A
1. Immunization (Hepatitis A)
   a. Dose #1 ____/____/____ b. Dose #2 ____/____/____
2. Immunization (Combined Hepatitis A and B Vaccine)
   a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

F. MENINGOCOCCAL
Tetravalent conjugate (Preferred; data for revaccination pending): Date: ____/____/____
Tetravalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5years if increased risk continues):
Date ____/____/____

G. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)
(Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)
Immunization (HPV)
a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

H. TUBERCULOSIS SCREENING
1. Does the student have signs of active tuberculosis disease? Yes ☐ No ☐
2. Is the student a member of a high-risk group or is the student entering the health profession? Yes ☐ No ☐
3. Tuberculin Skin Test Date Given ____/____/____ Date Read ____/____/____ Results _____
4. Chest x-ray (required if tuberculin skin test is positive) result: normal _____ abnormal _____ Date of chest x-ray: ____/____/____

I. INTERFERON GAMMA RELEASE ASSAY (IGRA)
Date Obtained ____/____/____ (specify method) QFT-G QFT-GIT other _____
Result: negative ____ positive ____ intermediate ____

J. CHEST X-RAY (Required if TST or IGRA is positive)
Date of chest x-ray ____/____/____ Result: normal ____ abnormal ____

HEALTH CARE PROVIDER (Please provide the official stamp with your name and address.)

Address _____

_____

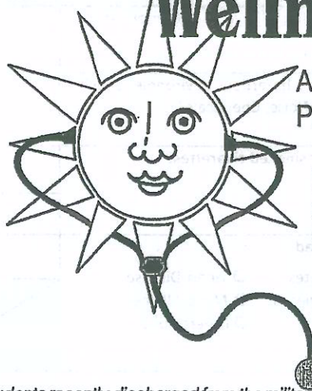
Signature: _____ Phone: ( ) _____

01.16.2013

TO BE COMPLETED BY PATIENT
Check major for which applied:
☐ NURSING
☐ TEACHER EDUCATION
☐ HEALTH SCIENCES
(field)_____

CHICAGO STATE UNIVERSITY

HEALTH CENTER USE ONLY
Allergies_____



Wellness/Health Center

ADMINISTRATION BUILDING, ROOM 131
PHONE 773 / 995-2010 • FAX 773 / 995-2953

MEDICAL RECORD

All information is strictly confidential

All students recently discharged from the military services may use a copy of their discharge physical if it was completed within 6 months of registration.

PLEASE PRINT ALL INFORMATION

Date of expected entrance _____ ID# _____

Name (Last, First, Middle) _____ Sex ☐ M ☐ F

Home Address _____ City/State _____ ZIP _____

Phone number _____ Marital status ☐ S ☐ M ☐ D ☐ W

Age _____ Birthday: Month ____ Day ____ Year _____ Year in School: ☐ Fr ☐ So ☐ Jr ☐ Sr ☐ Grad

In case of serious illness, please notify:

_____

Relationship_____ Telephone_____

Are you covered by any type of hospitalization or medical insurance (such as Blue Cross-Blue shield, HMO, Medicaid or Medicare)?

☐ No ☐ Yes Name of company _____ Identification number _____

PARENTAL PERMIT: The law requires that parental pemission be obtained for medical procedures on minors. The following consent should be signed by the parents or legal guardian so that ordinary medical care may be given without undue delay. However, no procedure will be performed without specific prior consent by parent or guardian.

Consent: "I hereby certify to the best of my knowledge that the preceeding is complete and correct.

_____do hereby authorize the Chicago State University Wellness/Health Center staff or their consultants to render whatever medical care they deem necessary for the health of (student's name) _____.

Date _____ Signed _____ Relationship _____