



Part 1 – To be completed by student

Last Name (Please Print)	First	Middle Initial	If available: Student ID # _____ Dominican email: _____
Date of Birth (Mo/Day/Yr)	Sex M F	Phone Number(s)	Term Attending (Check One) <input type="checkbox"/> Fall <input type="checkbox"/> Winter <input type="checkbox"/> Spring/Summer Year _____
I authorize Dominican University to release this immunization record to the Illinois Department of Public Health or its designated representative, for compliance audits and in the event of a health or safety emergency.			Last prior year in attendance at Dominican University? (former students only) _____ Were you born and educated grades 1 thru 12 in the United States? Yes <input type="checkbox"/> No* <input type="checkbox"/> (*See below)
Student's Signature _____ Date _____			

***All foreign-born students must show documentation of a minimum of 2 primary Tetanus AND a current TDAP.**

Part II – Required Vaccines To be completed and signed by health care provider * ALL DATES MUST INCLUDE MONTH, DAY & YEAR

Tetanus/Diphtheria

1. Primary Dates? (Should include at least two doses--
Indicate month, day and year)

Date ____/____/____
Month Day Year

Date ____/____/____
Month Day Year

2. Most recent booster (**Must be a "TDAP" within last 10 years**)

Date ____/____/____
Month Day Year

3. Exemption

Attach physician's statement of medical contraindication

Combined MMR (Measles Mumps Rubella)

Date ____/____/____
Month Day Year

Date ____/____/____
Month Day Year

Measles (Rubeola) – Two required after first birthday.

1. Immunization with live virus vaccine (Given in 1968 or later):

Date ____/____/____ (Dose 1)
Month Day Year

Date ____/____/____ (Dose 2)
Month Day Year

2. Disease confirmed by physician's records

Date of Illness: _____ Signature of Physician: _____

3. Immunity confirmed by blood titer:

Date of test _____ Attach copy of laboratory report

4. Exemption

Attach physician's statement of medical contraindication

Rubella (German Measles) – Two required after first birthday

1. Immunization with live virus vaccine

Date ____/____/____
Month Day Year

Date ____/____/____
Month Day Year

2. Immunity confirmed by blood titer

Date of test: _____ Attach copy of laboratory report

3. Exemption

Attach physician's statement of medical contraindication

Mumps – Two required after first birthday

1. Immunization with live virus vaccine

Date ____/____/____
Month Day Year

Date ____/____/____
Month Day Year

2. Disease confirmed by physician's records

Date of Illness: _____ Signature of Physician: _____

3. Immunity confirmed by acceptable laboratory test

Date of test: _____ Attach copy of laboratory report

4. Exemption

Attach physician's statement of medical contraindication

Menactra (Meningitis)

1. Immunization with live virus vaccine

Date ____/____/____ (Dose 1)
Month Day Year

Date ____/____/____ (Dose 2)
Month Day Year

LAST DOSE MUST BE AFTER 16TH BIRTHDAY

2. Exemption

Attach physician's statement of medical contraindication

Part III- Recommended Immunizations

Hepatitis B: Date ____/____/____ Date ____/____/____ Date ____/____/____ OR date of blood titer ____/____/____ **HPV:** Date ____/____/____

Varicella: Date ____/____/____ Date ____/____/____ OR date of blood titer ____/____/____ Date ____/____/____

Hepatitis A: Date ____/____/____ Date ____/____/____ OR date of blood titer ____/____/____ Date ____/____/____

Yellow Fever: Date ____/____/____ Date ____/____/____ OR date of blood titer ____/____/____ Date ____/____/____

Typhoid: Date ____/____/____ Date ____/____/____ OR date of blood titer ____/____/____ Date ____/____/____

Part IV- Health Care Provider or Official of the designated record keeping office verifying that above information is complete & accurate.

Health Care Provider: _____ Signature _____ Date: _____

Address: _____ Contact # _____

**Physician licensed to practice medicine in all of its branches (MD, DO) a local health authority, registered nurse employed by a school, college or university, or a departmentally recognized vaccine provider.*

NOTE: Illinois law (TITLE 77 PART 694 COLLEGE IMMUNIZATION CODE) requires incoming students taking 6 or more credit hours to document immunity to tetanus/diphtheria/pertussis, measles, rubella, mumps and meningitis.

The following rules will apply:

1. All dates must include Month, Day and Year.
2. Part II Proof of immunity may be provided by a copy of the student's Certificate of Child Health Examination from an Illinois high school which provides the complete information necessary to assure compliance with the Act. The Certificate of Child Health Examination must be reviewed for compliance and attached to this form. Part III need not be completed.

RULES FOR ACCEPTABLE IMMUNIZATIONS AND BLOOD TESTS PROVING IMMUNITY:

3. Part III: must be completed and signed by a health care provider
(Physician licensed to practice medicine in all of its branches (M.D. or D.O.), a local health authority, registered nurse employed by a school, college, or university, or a Department recognized vaccine provider)
 - All laboratory evidence of immunity must be accompanied by a copy of the laboratory report.
 - History of rubella disease is not acceptable as proof of immunity.
 - All live virus vaccines must have been given on or after the first birthday.
 - Mumps titer is only acceptable as proof of immunity if the laboratory used was a neutralization, enzyme-linked immunosorbent assay (ELISA or EIA) or radial hemolysis antibody test. A four-fold rise in antibody titer between appropriately spaced acute and convalescent sera is also acceptable.

RULES FOR EXEMPTIONS:

4. All students requesting a vaccine exemption must complete the Medical and Religious Exemption Form. The following will be considered for exemption:
 - Medical Contraindications: A completed Medical and Religious exemption form with a physician stating the specific vaccine or vaccines that are contraindicated due to a medical condition (this may include pregnancy).
 - Religious Exemption- A Completed Medical and Religious exemption form with a statement by the student (or parent /guardian if the student is a minor) describing his/her objection to immunization on the grounds that they conflict with the tenet and practices of a faith which the student is an adherent or member. This form must also be signed by a healthcare provider.
 - Students enrolled only in programs designated by the University as "Online Only".
5. **Anyone with a vaccine exemption may be excluded from the college/university in the event of a measles, rubella, mumps, diphtheria or SARS CoV2 outbreak in accordance with public health recommendations.**
6. **All records not in English must be accompanied by a certified translation.**
7. **Immunizations must be submitted through the Wellness Center Online Portal at dom.medicatconnect.com. Individuals will be subject to fines each semester if not compliant with the requirements.**

WELLNESS CENTER

Dominican University, 7900 W. Division St. River Forest, IL 60305

Phone: 708-524-6229