**IMMUNIZATION FORM**

7900 W. Division, River Forest, Illinois 60305  
PH: 708-524-6229  FAX 708-488-5072  
WWW.DOM.EDU/WELLNESS

MUST BE SUBMITTED ONLINE BEFORE FIRST DAY OF CLASS IN COMPLIANCE WITH ILLINOIS LAW. LATE SUBMISSIONS WILL BE SUBJECT TO FINE

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**Part I – To be completed by student**

<table>
<thead>
<tr>
<th>Last Name (please Print)</th>
<th>First Name (please Print)</th>
<th>Address: ____________________________________________________________________</th>
<th>Phone Number(s)</th>
<th>Term Attending (Check One)</th>
<th>Contact # ___________________________________</th>
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1. Immunization with live virus vaccine (Given in 1968 or later):  
2. Disease confirmed by physician’s records  
3. Immunity confirmed by blood titer:  
4. Exemption

**Part II – 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)  
2. Most recent booster **(Must be a “TDAP” within last 10 years)**

**Measles (Rubella) – Two required after first birthday**

1. Immunization with live virus vaccine:  
2. Disease confirmed by physician’s records  
3. Immunity confirmed by blood titer:  
4. Exemption

**Rubella (German Measles) – Two required after first birthday**

1. Immunization with live virus vaccine  
2. Immunity confirmed by blood titer  
3. Exemption

**Mumps – Two required after first birthday**

1. Immunization with live virus vaccine  
2. Disease confirmed by physician’s records  
3. Immunity confirmed by acceptable laboratory test  
4. Exemption

**Menactra (Meningitis)**

1. Immunization with live virus vaccine  
2. Exemption

**Last DOSE MUST BE AFTER 16th BIRTHDAY**

**Part III – Recommended Immunizations**

<table>
<thead>
<tr>
<th>Hepatitis B: Date / / / Date / / / OR date of blood titer / / / HPV: Date / / /</th>
<th>Varicella: Date / / / OR date of blood titer / / /</th>
<th>Hepatitis A: Date / / / OR date of blood titer / / /</th>
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**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.*
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. Only the following exemptions will be accepted and statements must accompany this record:
   - Medical Contraindications-A written, signed, and dated statement from a physician stating the specific vaccine or vaccines contraindicated and duration or medical condition that contraindicated the vaccine(s).
   - Religious Exemption-A written, signed, and dated 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 recognized church or religious organization, of which the student is an adherent or member.
   - Pregnancy or Suspected Pregnancy-A signed statement from a physician stating the student is pregnant or pregnancy is suspected and estimated date of confinement.
   - 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, or diphtheria 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.edu/wellness. 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