NORTH PARK UNIVERSITY

IMMUNIZATION RECORD

PART I - TO BE COMPLETED BY STUDENT (please print)

(Required only if you were born after 1956)

Name:_____ Date of Birth: _____/_____/_____

Last First Middle

Address: _____/_____/_____/_____ Telephone: (____) _____

Street City State Zip

Country of Birth: _____ Date of Enrollment: _____/_____

Mo. Yr.

Program (circle one) SAL MVP Sem CME MS Nsg NP MEd Teach.Cert. Other_____

I authorize North Park Health Services to release the 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.

Student's Signature: _____

PART II - TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER.*

All dates must include month, day, and year.

*Physician licensed to practice medicine in all of its branches (M.D. or D.O.) or Registered Nurse or a Public Health Official

RED MEASLES (Rubeola) Yes

Illness confirmed by physician _____ ( ) Date of Illness_____

MD signature

or Immunity confirmed by blood titer? Attach copy of lab report. ( ) Date of Test_____

or Immunization with live attenuated virus? **Dose #1:** ( ) Date_____

(Must be 1/1/68 or later and after student's 1st birthday)

2 doses REQUIRED in State of Illinois **Dose #2:** ( ) Date_____

GERMAN MEASLES (Rubella)

Immunity confirmed by blood titer? Attach copy of lab report. ( ) Date of Test _____

or Immunization with live attenuated virus? ( ) Date_____

MUMPS

Illness confirmed by physician _____ ( ) Date of Illness_____

MD signature

or Immunity confirmed by blood titer? Attach copy of lab report. ( ) Date_____

or Immunization with live attenuated virus? ( ) Date_____

TETANUS/DIPTHERIA

Primary series completed? ( ) Date _____

(International students must give all 3 dates of series) ( ) Date_____

( ) Date_____

Most recent booster? (**Must be within last 10 years**) ( ) Date_____

OTHER VACCINES (Hepatitis B vaccine recommended)

Vaccine and date given: _____ _____

_____ _____

ALL MEDICAL OR RELIGIOUS EXEMPTIONS TO THE ABOVE VACCINES MUST BE IN WRITING AND SIGNED BY A PHYSICIAN OR RELIGIOUS PRACTIONER.

TUBERCULIN TEST – MANTOUX (PPD) REQUIRED for international students.

Date _____ Reaction in mm: _____ Signature _____

Previous positive PPD: No _____ Yes/Date _____ Previous BCG: No_____ Yes _____ Date _____

Follow-up to positive PPD: Chest x-ray: No_____ Yes/Date_____ Results:_____

INH: No_____ Yes/Dates_____

Name of Health Care Provider verifying above information (Print):_____

Telephone: (_____)_____ Date: _____ Signature_____

Return to : North Park Health Center, 3225 W. Foster Ave., Box 26, Chicago, IL 60625

Telephone: 773-244-4897 Fax: 773-244-4888

Location: 3317 W. Foster Ave.