

**IMMUNIZATION RECORD**

NAME \_\_\_\_\_ M \_\_\_ F \_\_\_  
last first middle

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Country of birth: \_\_\_\_\_  
month day year

Date of Enrollment: \_\_\_\_\_ / \_\_\_\_\_ Undergraduate \_\_\_\_\_ Year: 1 2 3 4 OR Seminary \_\_\_\_\_  
month year

**Attach copy of previous immunization certificate if used as source of following vaccine dates.**

To be completed and signed by Health Care Provider ALL DATES MUST HAVE MONTH, DAY AND YEAR

REQUIRED IMMUNIZATIONS	Vaccine Date	Vaccine Date	Alternate Proof of Immunity
<b>MEASLES</b> (rubeola): Two doses of live vaccine or two doses of MMR separated by at least one month are required. <b>First dose must be January 1, 1968 or later, and on or after first birthday.</b> MMR is preferred for second dose.	1	2	Date of Disease: M.D. Signature:
			<u>OR</u> Date of Titer: (Attach copy of result)
<b>RUBELLA</b> (German measles): Immunization with live vaccine must be <b>June 19, 1969 or later, and on or after first birthday.</b>	1		Date of Titer: (Attach copy of result)
<b>MUMPS:</b> Immunization with live vaccine must be <b>January 1, 1968 or later, and on or after first birthday.</b>	1		Date of Disease: M.D. Signature:
			<u>OR</u> Date of Titer: (Attach copy of result)
<b>MMR</b> (measles, mumps, rubella): Two doses of MMR, separated by more than one month eliminate the need for all of the above vaccinations. <b>First dose must be May 1, 1971 or later, and on or after first birthday.</b> (See measles section.)	1	2	
<b>TETANUS/DIPHTHERIA:</b> Last dose must be within last 10 years. <b>International students are required to show 3 dates of vaccination</b>	1 DTP Series	2	3
			Booster within last 10 years
____ If exempt from any of the above vaccines, attach a written, signed statement from a physician or a religious practitioner.			

Polio: Primary Series - Date Completed: \_\_\_\_\_ Last Booster: \_\_\_\_\_

Recommended Vaccines:

Hepatitis B: 1st \_\_\_\_\_ 2nd \_\_\_\_\_ 3rd \_\_\_\_\_  
month / day / year month / day / year month / day / year

Menomune (meningitis): \_\_\_\_\_

Other Vaccines:

**Tuberculosis :** PPD test (Mantoux) within past year required UNLESS:  
 positive PPD result\* in past **OR** BCG vaccine given in past five years\*\*.

**PPD Date:** \_\_\_\_\_ **Date Read:** \_\_\_\_\_ **Result in mm:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

\*If positive PPD result (current or in past): attach copy of chest x-ray result and record of INH prophylaxis.

\*\*Chest x-ray required - attach copy of report.

**Health Care Provider (Physician, Nurse, or Public Health Official) verifying above information:**

Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Note: This form must be completed and returned to Health Services by all students. Athletic and nursing physicals are separate and additional, and are not a substitution for the Health Service form. PLEASE READ ALL PARTS OF THIS FORM AND THE ACCOMPANYING LETTER CAREFULLY.

All medical records and information are strictly confidential and will not be released without your consent.

**MEDICAL HISTORY RECORD**

PERSONAL HISTORY: Explain positive answers and make additional comments on back of form.

Have You Had?	No	Yes	Date	Have You Had?	No	Yes	Date	Have You Had?	No	Yes	Date
Allergies, seasonal				Eating Disorder				Pneumonia			
Anemia				Epilepsy				Pregnancy			
Arthritis				Eye Problem				Sinus Condition			
Asthma, chronic				Fracture/Sprain				Skin Disorders/Acne			
Asthma, exercise induced				Gall Bladder Disease				Stomach Disorders			
Back Problem				Head Injury				Strep Throat (freq)			
Bronchitis				Headaches (freq)				Sexually Trans. Diseases			
Cancer				Heart Condition/Murmur				Surgery			
Chicken Pox				Hepatitis				—Appendectomy			
Chronic Cough				High Blood Pressure				—Tonsillectomy			
Counseling				HIV/AIDS				—Other			
Depression (freq)				Kidney Problems				Thyroid Disorder			
Diabetes				Malaria				Tuberculosis			
Diarrhea (recurrent)				Menstrual Problems				Tumor/Cyst			
Dizzy Spells/Fainting				Mononucleosis				Urinary Tract Infection			
Ear, Nose, Throat Disorder				Paralysis				Weight gain or loss, recent			

**HOSPITALIZATIONS:**                      Reason    Date

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Has your physical activity been restricted during the past five years?     No     Yes  
 (Give reasons and duration) \_\_\_\_\_

Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?     No     Yes  
 (Give details) \_\_\_\_\_

Have you traveled or resided outside of the United States?                       No     Yes  
 If yes, where and when? \_\_\_\_\_

Date of last physical examination by a physician: \_\_\_\_\_

**CURRENT HEALTH**

LIST **ALLERGIES** TO DRUGS, FOODS, POLLEN, MOLDS, OTHER: \_\_\_\_\_

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LIST **MEDICATIONS** TAKEN REGULARLY \_\_\_\_\_

Do you smoke cigarettes?     No     Yes    Number per day \_\_\_\_\_  
 Do you drink coffee?         No     Yes  
 Do you drink alcohol?        No     Yes    How much? \_\_\_\_\_  
 Do you wear glasses?        No     Yes    Contact Lenses?     No     Yes

**FAMILY HISTORY**

	Age	State of Health				Age of Death	Cause of Death
		Good	Fair	Poor	Deceased		
Father							
Mother							
Brothers							
and							
Sisters							
Spouse							
Children							

Have any of your blood relatives ever had any of these?	No	Yes	Relationship
Alcoholism			
Arthritis			
Asthma			
Cancer			
Diabetes			
Epilepsy			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Mental Illness			
Stroke			
Suicide			
Thyroid Disease			
Tuberculosis			

**I hereby certify to the best of my knowledge that the preceding information is complete and correct. I authorize North Park University 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.**

\_\_\_\_\_  
*Signature of Student*

\_\_\_\_\_  
*Date*

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

**If examined by a physician:**

Statement: I find the above student to be in good physical and emotional health and find no reason why he/she cannot participate in normal University activities.

\_\_\_\_\_  
*Signature of Physician*

\_\_\_\_\_  
*Date*

**ADDITIONAL DATA**

**Health Insurance**

Company/Organization: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Student Insurance \_\_\_\_\_ Private \_\_\_\_\_ Insured's Name \_\_\_\_\_

**Home Address**

\_\_\_\_\_  
*Number and Street* *City/Town*

\_\_\_\_\_  
*State or Province* *Country* *Zip Code or Postal Code*

\_\_\_\_\_  
*Telephone Number* *Social Security Number (if available)*

**Emergency Notification**

\_\_\_\_\_  
*Name* *Relationship*

\_\_\_\_\_  
*Address Number and Street*

\_\_\_\_\_  
*City/Town* *State/ Province* *Country* *Zip Code/Postal Code*

Telephone: Home \_\_\_\_\_ Business \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

**DETAILS OF MEDICAL HISTORY FROM PAGE TWO**