Immunization Record

North Park University Health Center
3225 West Foster Avenue, Box 26
Chicago, Illinois 60625-4895

Phone: (773) 244-4897
Fax: (773) 634-4060

Name_____ ☐ Female ☐ Male
(Last) (First) (MI)

Date of birth _____ Country of birth_____

Date of enrollment (month/year)_____

☐ Undergraduate Year (circle one) 1 2 3 4 _____

☐ Seminary

Immunizations

To be completed and signed by your Health Care Provider. All dates must have month, day, and year. Attach a copy of previous immunization certificate if used as source of following vaccine dates. An official print out from: your electronic medical record, immunizations record from high school or copy of an authorized immunization record can serve as a replacement of this first page.

Required Immunizations	Vaccine Date	Vaccine Date	Alternate Proof of Immunity
Measles (rubeola): Two doses of live vaccine or two doses of MMR separated by at least one month are required.	1 (MM/DD/YY)	2 (MM/DD/YY)	Date of disease: M.D. Signature: (Attach copy of result)
Rubella (German measles): Immunization with live vaccine must be June 19, 1969 or later, and on or after first birthday.	1 (MM/DD/YY)		Date of Disease or Titer: (Attach copy of result)
Mumps: Immunization with live vaccine must be January 1, 1968 or later, and on or after first birthday.	1 (MM/DD/YY)		Date of Disease or Titer: M.D. Signature: (Attach copy of result)
MMR (measles, mumps, rubella): Two doses of MMR, separated by more than one month eliminate the need for all the above vaccinations. First dose must be May 1, 1971 or later, and on or after first birthday. (See measles section.)	1 (MM/DD/YY)	2 (MM/DD/YY)	
Tetanus/Diphtheria: Last dose must be within last 10 years. International students are required to show 3 dates of vaccination.	1 (DTP Series) (MM/DD/YY)	2 (MM/DD/YY)	3 (Booster within last 10 years) (MM/DD/YY)

☐ **Check if exempt from any of the above vaccines. Attach a written and signed statement from a physician or a religious practitioner.**

Recommended Vaccines: Please provide month, day, and year.

Hepatitis B: 1st_____ 2nd_____ 3rd_____ **Menactra (MCV4) OR Menomune:**_____
(MM/DD/YY) (MM/DD/YY) (MM/DD/YY) (Circle) (MM/DD/YY)

Polio–Primary Series: Date completed _____Last Booster: _____
(MM/DD/YY) (MM/DD/YY)

Other Vaccines: (An authorized print out or copy of an official immunization record is acceptable.) _____

_____

International Students

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

PPD Date: _____ Date Read: _____Result in mm: _____
(MM/DD/YY) (MM/DD/YY)

Signature: _____

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

** Chest X-ray required. Attach a copy of report.

Signature

A Health Care Provider (Physician, Nurse, or Public Health Official) verifies the above information:

Print name: _____ Date:_____

Signature:_____ Title:_____

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.

Medical History Record

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

Personal History

This portion may be completed by student, parent or guardian. 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 problems				Head Injury				Strep Throat (frequent)			
Bronchitis				Headaches (frequent)				Sexually Transmitted Disease			
Cancer				Heart Condition/Murmur				Surgery –			
Chicken Pox				Hepatitis				– Appendectomy			
Chronic Cough				High Blood Pressure				– Tonsillectomy			
Counseling				HIV/AIDS				– Other			
Depression (frequent)				Kidney problems				Thyroid Disorder			
Diabetes				Malaria				Tuberculosis			
Diarrhea (recurrent)				Menstrual problems				Tumor/Cyst			
Dizzy Spells/Fainting				Mononucleosis				Urinary Tract Information			
Ear, Nose, Throat Disease				Paralysis				Weight gain or loss, recent			

Hospitalizations: Provide reason and the date(s):_____

_____

Has your physical activity been restricted during the past five years? ☐ Yes ☐ No Provide reasons and duration: _____

_____

Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? ☐ Yes ☐ No

Provide details: _____

Have you traveled or resided outside of the United States? ☐ Yes ☐ No Provide where and when: _____

Date of last physical examination by a physician: _____

Current Health

List allergies to drugs, foods, pollen, molds, other _____

_____

List medications taken regularly _____

Do you smoke? ☐ No ☐ Yes

Do you drink coffee? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes

Contact lenses? ☐ No ☐ Yes

Family History The family history may be completed by student, parent or guardian.

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

Have any of your blood relatives had:

Alcoholism ☐ No ☐ Yes Relationship: _____
Arthritis ☐ No ☐ Yes Relationship: _____
Asthma ☐ No ☐ Yes Relationship: _____
Cancer ☐ No ☐ Yes Relationship: _____
Diabetes ☐ No ☐ Yes Relationship: _____
Epilepsy ☐ No ☐ Yes Relationship: _____
Heart Disease ☐ No ☐ Yes Relationship: _____
High Blood Pressure ☐ No ☐ Yes Relationship: _____
Kidney Disease ☐ No ☐ Yes Relationship: _____
Mental Illness ☐ No ☐ Yes Relationship: _____
Stroke ☐ No ☐ Yes Relationship: _____
Suicide ☐ No ☐ Yes Relationship: _____
Thyroid Disease ☐ No ☐ Yes Relationship: _____
Tuberculosis ☐ No ☐ Yes Relationship: _____

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 (not required for admission):

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. Please attach copy of physical if done.

Signature of Physician _____

Date _____

Please use this space if you need to add further comments to your personal medical history on page 2 of this form. Thank you.