DEPAUL UNIVERSITY

in partnership with Higher Education

IMMUNIZATION FORM

Please have your healthcare provider complete and sign this form.
Bring the completed form with you.
For more information visit: **go.depaul.edu/immunizations**

Student Information

This section must be completed

Last Name

First Name and Middle Initial

Date of Birth MM DD YYYY Student Ref# International Student? F-1 ☐ Yes ☐ No

Email address

I authorize DePaul University and the Global Pathway Program to release this immunization record to the Illinois Department of Public Health, or its designated representative for compliance audits or in the event of a health emergency. All immunization documents submitted to DePaul become the property of the University. I understand that, unless required to do so by law, DePaul University or the Global Pathway Program will not re-release my immunization documentation to me or any other academic institution or third party.

Student Signature

Date MM DD YYYY

Please complete either Option A or Option B

Option A ☐ Include a copy in English of your Official Immunization Records proving ALL immunizations. (SKIP OPTION B)

Option B ☐ See below – Remainder of form to be completed and signed by physician or health care provider.

Option B

To be completed and signed by physician or health care provider. **Please note the following:**

- Positive laboratory (serologic) evidence of immunity via blood (antibody) titer is acceptable proof for Measles, Mumps and Rubella.
- Include all lab evidence with copy of lab report.
- Anyone with a vaccine exemption may be excluded from the college/university in the event of an outbreak in accordance with public health recommendations.
- All documents must be in English or accompanied by a certified translation.

TETANUS | DIPHTHERIA | PERTUSSIS

3 doses required, last dose within the past 10 years. At least 1 dose of Tdap in lifetime must be submitted.

DOSE 1

Td ☐ DTap ☐ Tdap ☐ Date MM DD YYYY

DOSE 2

Td ☐ DTap ☐ Tdap ☐ Date MM DD YYYY

DOSE 3

Td ☐ DTap ☐ Tdap ☐ Date MM DD YYYY

MENINGOCOCCAL CONJUGATE

1 dose required if under 22 years old, taken on or after the age of 16.

DOSE 1

MM DD YYYY

MEASLES/ MUMPS/ RUBELLA

2 doses required of MMR or each individually, at least 28 days apart, after 12 months of age. Neither dose can be prior to 1968.

MMR DOSE 1 MM DD YYYY

MMR DOSE 2 MM DD YYYY

MEASLES DOSE 1 MM DD YYYY

MEASLES DOSE 2 MM DD YYYY

☐ **OR** positive blood titer with REQUIRED copy of lab report.

MUMPS DOSE 1 MM DD YYYY

MUMPS DOSE 2 MM DD YYYY

☐ **OR** positive blood titer with REQUIRED copy of lab report.

RUBELLA DOSE 1 MM DD YYYY

RUBELLA DOSE 2 MM DD YYYY

☐ **OR** positive blood titer with REQUIRED copy of lab report.

Physician or public health official verification - *I verify to the best of my knowledge that the above immunization* information is correct.

Physician Name (print or stamp)

Physician's Phone #:

Date MM DD YYYY

Signature

For DePaul Central Office Use Only:

Date MM DD YYYY Staff Initials Partial ☐ Complete ☐ Hold Removed ☐