# REQUIRED FOR CHICAGO CAMPUS
## IMMUNIZATION RECORD

## PART 1 – To be Completed By Student

| Last Name | First | Middle | Student ID | Student Phone ( ) |
|---|---|---|---|---|
| | | | | |

| Home Address | Date of Enrollment ☐ Undergraduate<br>☐ Fall ☐ Spring Year_____ ☐ Graduate |
|---|---|
| City/State/Country/Zip or Postal Code | E-mail Address |

| Date of Birth (mm/dd/yyyy) | Age | Gender<br>☐ Male ☐ Female | Citizenship<br>☐ U.S. ☐ Other (specify) | F-1 International Student Visa<br>☐ Yes ☐ No |
|---|---|---|---|---|
| | | | | |

I hereby Authorize Moody Bible Institute Health Service to make this Immunization Record available to the Illinois Department of Public Health or its designated representative.

| Student Signature | Date of Signature |
|---|---|
| Parent/Guardian Signature (if under 18) | Date of Signature |

## PART 2 – To be Completed by a Health Care Provider*

### REQUIRED IMMUNIZATIONS (dates required)

**Licensed Provider: Complete Immunization documentation or attach signed physician/school immunizations.**

**A. MEASLES-MUMPS-RUBELLA** – 2 shots against measles, mumps, and rubella (exempt if born before 1/1/57)

| | | | | |
|---|---|---|---|---|
| **MMR**<br>2 doses at least 28 days apart<br>AND after 12 months of age<br>AND both given after 12/31/1967 | 1 mm/dd/yy<br>2 mm/dd/yy | ***OR*** | **MEASLES (Rubeola)**<br>2 doses at least 28 days apart<br>AND after 12 months of age<br>AND both given after 12/31/1967 | 1 mm/dd/yy<br>2 mm/dd/yy |
| **Positive serum titers are also acceptable proof of immunity against measles, mumps and rubella.**<br>☐ Required lab report attached. | | | **MUMPS**<br>2 doses at least 28 days apart<br>AND after 12 months of age. | 1 mm/dd/yy<br>2 mm/dd/yy |
| Documentation of dates of disease **IS NOT** acceptable evidence of immunity against measles, mumps or rubella. | | | **RUBELLA**<br>2 doses at least 28 days apart<br>AND after 12 months of age. | 1 mm/dd/yy<br>2 mm/dd/yy |

**B. TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DTaP, TD, Tdap)**
**3 or more doses of diphtheria, tetanus vaccine. One dose MUST be a Tdap.**
*The most recent vaccine must have been administered within the last 10 years.

| 1 *after 2 months of age* | 2 *A minimum of 28 days after the first* | 3 **REQUIRED Within 10 Years** |
|---|---|---|
| ☐ DTaP/DPT ☐ Tdap ☐ TD ____/____/____ | ☐ DTaP/DPT ☐ Tdap ☐ TD _____/_____/_____ | ☐ **Tdap** _____/_____/_____ |
| **mm/dd/yy** | **mm/dd/yy** | **mm/dd/yy** |

**C. MENINGOCOCCAL CONJUGATE VACCINE -** The Meningococcal Conjugate Vaccine (MenACWY) **is REQUIRED after the age of 16** for all students 21 and younger. **Menomune and Meningitis B do not meet this requirement.**

1 mm/dd/yy

2 mm/dd/yy

### RECOMMENDED IMMUNIZATIONS (complete if received)

| | | | |
|---|---|---|---|
| ☐ HEPATITIS A | 1 mm/dd/yy | 2 mm/dd/yy | |
| ☐ HEPATITIS B | 1 mm/dd/yy | 2 mm/dd/yy | 3 mm/dd/yy |
| ☐ VARICELLA | 1 mm/dd/yy | 2 mm/dd/yy | ☐ Had Varicella Disease (Chickenpox) |
| ☐ OTHER (Specify) | 1 mm/dd/yy | 2 mm/dd/yy | 3 mm/dd/yy |

### Required Healthcare Provider Verification*

| Provider Name (print or stamp) | Title | Signature | Date |
|---|---|---|---|
| | | | |

| Address | Phone | Fax |
|---|---|---|
| | | |

*A "Health Care Provider" is defined as an M.D., D.O. or R.N, who is not a family member. It may also be an L.P.N or Medical Assistant who has had specific training in administering and reading Mantoux TB skin tests and Vaccines and who is directly supervised by an M.D. or R.N.