

GOVERNORS STATE UNIVERSITY
Mandatory Student Immunization History

Summer/Fall 2016

Deadline: Submit by September 14, 2016

Part I: Submit completed form to **immunizations@govst.edu** or fax to 708.235.3961.

Name - Last	First	Birth Date (mm/dd/yyyy)	GSU ID #
Phone	Cell	M / F Sex (please circle)	

International Student* Yes No *Additional immunization requirements apply

Initial semester attending GSU Spring Summer Fall 20_____

PRIVACY RIGHTS WAIVER: I AUTHORIZE Governors State University to release this immunization record to the Illinois Department of Public Health or its designated representative for compliance audits in accordance with Illinois Immunization Law. (Public Act 85-1315) This release also applies in the event of a health or safety emergency.

Student Signature _____ Date _____

Part II: Required Immunizations (to be completed by licensed healthcare provider)

Tdap One booster of Tetanus/Diphtheria/Acellular/Pertussis within last 10 years. Tetanus Toxoid (T.T.) NOT acceptable, per state law.	Booster Dose ____/____/____ (mm/dd/yyyy)
MMR (Measles, Mumps, Rubella) Two doses required, at least one month apart, after 12 months of age AND after 12/31/67.	Dose 1 ____/____/____ Dose 2 ____/____/____ (mm/dd/yyyy) (mm/dd/yyyy)
If MMR was not given, individual immunizations or titers should be listed below	
Measles (Rubeola) 2 doses required. Both must be done on or after 1st birthday and at least 28 days apart. (mm/dd/yyyy) Dose 1 ____/____/____ Dose 2 ____/____/____ OR Date of Illness ____/____/____ OR Attach copy of lab report (titer) confirming immunity.	Mumps 2 doses required on or after 1st birthday (mm/dd/yyyy) Dose 1 ____/____/____ Dose 2 ____/____/____ OR Date of Illness ____/____/____ OR Attach copy of lab report (titer) confirming immunity.
Rubella (German Measles)* 2 doses required on or after 1st birthday (mm/dd/yyyy) Dose 1 ____/____/____ Dose 2 ____/____/____ OR Attach copy of lab report (titer) confirming immunity. *Date of illness not accepted for Rubella	
Meningococcal/Meningitis Vaccine—required if born <u>from 1995 to 2000 and vaccine is given after 16th birthday</u> <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo <input type="checkbox"/> Other Dose ____/____/____	

Part III: Recommended, but Not Required (to be completed by licensed healthcare provider)

Hepatitis B	Dose 1 ____/____/____	Dose 2 ____/____/____	Dose 3 ____/____/____
Varicella Vaccine <input type="checkbox"/> Had Chickenpox	Dose 1 ____/____/____	Dose 2 ____/____/____	OR Attach copy of lab report (titer) confirming immunity

Part IV: Required for International Students Only (to be completed by licensed healthcare provider)

Tuberculosis Screening Requirement Must be performed within the last 12 months in the United States	Quanti-FERON TB-Gold Lab test (attach lab report) Date ____/____/____ Has patient had a history of positive skin test? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient received BCG? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient received INH? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes" attach supporting documentation.</i>	Tuberculosis Skin Test Date: ____/____/____ Results <input type="checkbox"/> Negative <input type="checkbox"/> Positive Persons with a positive skin test must have further screening with a chest x-ray.
Tetanus/Diphtheria Series Additional requirements are required for international students. Must list at least 2 dates from primary series (usually done in childhood) and must be at least 28 days apart	Dose 1 ____/____/____ (mm/dd/yyyy) Dose 2 ____/____/____ (mm/dd/yyyy)	

Licensed healthcare provider's signature and/or electronic signature verifying above information
OR records with signature attached verifying information.

Healthcare Provider's Name / Title (print) _____ Signature _____ Date _____

Address _____ Phone _____