Student's Name _____

IC ID Number _____

IMMUNIZATION RECORD

Please give this form to your physician, nurse practitioner or physician's assistant.

As of July 1989, all students born after January 1, 1957 registering for the first time at public or private colleges in Illinois must present evidence of immunity against the vaccine-preventable diseases. If no proof of immunization, certification of medical exemption, or statement of religious objection is presented, the student will not be permitted to register for courses (Public Act 85-1315). *Required for entrance.

TO THE EXAMINING PROVIDER: Please complete and sign the Immunization Record. This information is necessary for the College to best serve the student. ❑ Check here to see attached immunization records.

Please scan and upload at **login.ic.edu** in the Chesley Health and Wellness App. Contact **217.245.3038** with any questions.

STUDENT INFORMATION

Student's Name _____ Date of Birth: _____

REQUIRED IMMUNIZATIONS:

A. MMR (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

Dose 1 given at age 12 months or later #1 ___/___/___

Dose 2 given at least 28 days after first dose #2 ___/___/___

B. MENINGOCOCCAL QUADRIVALENT

(Illinois Law: Students must have had one meningococcal conjugate after age of 16.) *Not required for students over the age of 22.*

1. Quadrivalent conjugate (MenACWY) or (MCV4).
   a. Dose #1___/___/___
   b. Dose #2 ___/___/___
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date: ___/___/___

C. TETANUS, DIPHTHERIA, PERTUSSIS

(Illinois Law: Students must have had a TDAP within the last 10 years)

1. Primary series completed? ❑ Yes ❑ No
   Date of last dose in series: ___/___/___
2. Date of most recent booster dose: ___/___/___
   Type of booster: ❑ Td ❑ Tdap *Tdap booster recommended for ages 11-64 unless contraindicated.*

STRONGLY RECOMMENDED IMMUNIZATIONS:

D. HEPATITIS B

(All college and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11–15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (Hepatitis B)
   a. Dose #1 ___/___/___ ___Adult formulation or ___Child formulation
   b. Dose #2 ___/___/___ ___Adult formulation or ___Child formulation
   c. Dose #3 ___/___/___ ___Adult formulation or ___Child formulation
2. Immunization (Combined Hepatitis A and B vaccine)
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___
   c. Dose #3 ___/___/___
3. Hepatitis B surface antibody Date: ___/___/___ Result: ❑ Reactive ❑ Non-reactive

E. INFLUENZA

❑ Trivalent (IIV3) - Date of last dose: ___/___/___

❑ Quadrivalent (IIV4) ❑ Recombinant (RIV3) ❑ Live attenuated influenza vaccine (LAIV)

F. VARICELLA

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of disease: ❑ Yes ❑ No or Birth in U.S. before 1980: ❑ Yes ❑ No
2. Varicella antibody: ___/___/___ Result: ❑ Reactive ❑ Non-reactive
3. Immunization: Dose #1 ___/___/___
   Dose #2 given at least 12 weeks after first dose ages 1–12 years and at least 4 weeks after first dose if age 13 years or older ___/___/___

G. HUMAN PAPILLOMAVIRUS VACCINE (HPV2/HPV4/HPV9)

(Three doses of vaccine for females and males 11–26 years of age at 0, 1–2, and 6 month intervals.)

Immunization (indicate which preparation, if known)

❑ Quadrivalent (HPV4) ❑ Bivalent (HPV2) ❑ 9-valent (HPV9)

a. Dose #1 ___/___/___

b. Dose #2 ___/___/___

c. Dose #3 ___/___/___

H. HEPATITIS A

1. Immunization (Hepatitis A):
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___
2. Immunization (Combined Hepatitis A and B vaccine):
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___
   c. Dose #3 ___/___/___

I. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

❑ PCV 13 Date ___/___/___ ❑ PPSV 23 Date ___/___/___

J. POLIO

Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.

1. OPV alone (oral Sabin three doses):
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___
   c. Dose #3 ___/___/___
2. IPV/OPV sequential:
   IPV #1___/___/___
   IPV #2___/___/___
   OPV #3___/___/___
   OPV #4___/___/___
3. IPV alone (injected Salk four doses):
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___
   c. Dose #3 ___/___/___
   d. Dose #4 ___/___/___

K. MENINGOCOCCAL SEROUGROUP B

(Two or three dose series; may be given to any college student or for outbreak control; may be given with quadrivalent meningococcal vaccine at different anatomic site. Must complete series with the same vaccine.)

1. MenB-RC (Bexsero) ❑ routine ❑ outbreak –related
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___

OR

1. MenB-FHbp (Trumenba) ❑ routine ❑ outbreak –related
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___

L. COVID-19 (SARS-CoV-2)

1. Moderna
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___
   c. Dose #3 ___/___/___
   d. Dose #4 ___/___/___
2. Pfizer
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___
   c. Dose #3 ___/___/___
   c. Dose #4 ___/___/___
3. Johnson & Johnson
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___
4. Other
   a. Dose #1 ___/___/___
   b. Dose #2 ___/___/___

HEALTH CARE PROVIDER CERTIFICATION

Health Care Provider (please print) _____

Health Care Provider's Signature _____ Date _____

Address _____

Telephone _____ Fax _____

ILLINOIS COLLEGE

Chesley Health and Wellness Center
phone: 217.245.3038 :: email: health@ic.edu

App: Scan and upload at login.ic.edu in the Chesley Health and Wellness App