

CHICAGO STATE UNIVERSITY

WELLNESS/HEALTH CENTER

9501 S. King Drive / ADM 131
Chicago, Illinois 60628-1598
TEL (773) 995-2010 • FAX (773) 995-2953

Dear Student:

Illinois Department of Public Health Part 694 College immunization code specifies that any student born on or after January 1, 1957, is required to show proof of immunizations. In order for you to continue your matriculation at Chicago State University, you must show documented proof of the following immunizations indicated below. Prior to registration, data must include (MONTH, DAY AND YEAR). All dates in a series must be included. ALL INFORMATION MUST BE WRITTEN IN ENGLISH. In order to be compliant with this legislation, all information must be submitted in its entirety.

Remember: Future registration and matriculation at Chicago State University will be in jeopardy if you do not comply with this requirement. Students who fail to comply, will be assessed a \$25.00 non-compliance fee.

REQUIRED PROOF

- Tetanus Diphtheria (Td/Tdap) Booster every 10 years.
- Measles, Mumps, Rubella (MMR) - documentation of two live doses of Measles Virus vaccine or proof of immunity to measles, mumps and rubella by titer. Titer must include full laboratory parameters.
- Tuberculin skin test (PPD/Mantoux test) within one year is required for residence hall students and some academic majors. If a past TB skin test resulted in a positive reaction, a chest x-ray is required, and a copy of the radiology report bearing your name should be submitted to the Wellness/Health Center.

STRONGLY RECOMMENDED

- Hepatitis B Series or documented proof of immunity.
- Varicella Vaccine or documented proof of immunity.
- Meningococcal (One dose-preferably at entry into college for students who wish to reduce their risk of meningococcal disease). Meningococcal disease is a potentially life-threatening bacterial infection. Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses. Immunization is recommended by the Advisory Committee on Immunization Practice (ACIP), Center's for Disease Control (CDC), and the American College Health Association (ACHA).

The tuberculin skin test (PPD) is also available for a minimal cost. You may see your primary health care provider or your local public health clinic for immunizations. Before going to a Public Health Clinic, you must call for an appointment, when obtaining immunizations, take a copy of your immunization records and the reverse side of this letter for completion by your provider. Please make two (2) copies of your health data. Keep one copy for yourself and submit the other copy to the Wellness/Health Center.

Residence hall students are required to submit a recent medical history and physical to the Wellness/Health Center before moving into campus housing.

Students are exempt from the immunization requirements of this Part if they are enrolled for:

- a) Instruction solely involving research, field work, or study outside of a classroom environment; or
- b) Instruction that utilizes correspondence as its primary mode of delivery. This includes students who are only enrolled in courses with no direct (physical) interaction occurs between the student and others receiving similar instruction (e.g., telecourses, courses by way of mail).

PLEASE MAIL INFORMATION OR FAX TO:

Chicago State University
Wellness/Health Center
9501 S. King Drive • Chicago, IL
Cook Administration Building, Room 131
TEL 773.995.2010 • FAX 773.995.2953

Rev: 03/26/10

Student Immunization Record

Last Name _____ First Name _____ Middle Name _____

Address _____

Street _____ City _____ State _____ Zip _____

Phone Number ____-____-____ Date of Entry ____/____/____ Date of Birth ____/____/____ SSN# _____ Student ID# _____

Status Male Female Part-time Full-time Graduate Undergraduate Professional

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. All information must be in English.

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)

1. Dose 1 given at age 12-15 months or later..... #1 ____/____/____
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose..... #2 ____/____/____

B. TETANUS-DIPHTHERIA (Primary series with DTaP or DTP and booster with Td/Tdap in the last ten years meets requirement. Refer to ACIP for details.)

1. Primary series of four doses with DTaP or DTP:
#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____
2. Tetanus-Diphtheria (Td/Tdap) booster within the last ten years ____/____/____

C. VARICELLA (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized at the age of 13 or older meets the requirement.)

1. History of Disease Yes No
2. Varicella Antibody ____/____/____ Reactive _____ Non-reactive _____
3. Immunization
 - a. Dose #1 #1 ____/____/____
 - a. Dose #2, given at least one month after first dose, if age 13 years or older #1 ____/____/____

D. HEPATITIS B (Three doses of a 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 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____
2. Hepatitis B Surface antibody Date ____/____/____ Result: Reactive _____ Non-reactive _____

E. 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 ____/____/____

F. MENINGOCOCCAL

Tetravalent conjugate (Preferred; data for revaccination pending): Date: ____/____/____
 Tetravalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5years if increased risk continues):
 Date ____/____/____

G. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)

(Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)
 Immunization (HPV)
 a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

H. TUBERCULOSIS SCREENING

1. Does the student have signs of active tuberculosis disease? Yes No
2. Is the student a member of a high-risk group or is the student entering the health profession? Yes No
3. Tuberculin Skin Test Date Given ____/____/____ Date Read ____/____/____ Results _____
4. Chest x-ray (required if tuberculin skin test is positive) result: normal _____ abnormal _____ Date of chest x-ray: ____/____/____

I. INTERFERON GAMMA RELEASE ASSAY (IGRA)

Date Obtained ____/____/____ (specify method) QFT-G QFT-GIT other _____
 Result: negative _____ positive _____ intermediate _____

J. CHEST X-RAY (Required if TST or IGRA is positive)

Date of chest x-ray ____/____/____ Result: normal _____ abnormal _____

HEALTH CARE PROVIDER (Please provide the official stamp with your name and address.)

Address _____

Signature: _____ Phone: () _____