CAMPUS BOX 1055
0214 RENDLEMAN HALL
EDWARDSVILLE IL 62026-1055

PHONE: (618) 650-2843
FAX: (618) 650-5839

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

IMMUNIZATION INFORMATION FORM

PART I: GENERAL INFORMATION – TO BE COMPLETED BY STUDENT. **PLEASE PRINT**

_____ _____ _____
Last Name First Name Middle Initial

_____ _____ Male___ Female___
Social Security Number Date of Birth (MO/DAY/YR)

First semester at SIUE: Fall___ Spring___ Summer___ **YEAR_____** International Student: Yes___No____

PART II: IMMUNIZATION INFORMATION – TO BE COMPLETED, SIGNED, AND DATED BY HEALTH CARE PROVIDER

Requirements for : ***(*) US Students*** ***(+)International Students***

Immunization :	MO	1 DY	YR	MO	2 DY	YR	MO	3 DY	YR	MO	4 DY	YR	MO	5 DY	YR
(+) Diphteria, Pertussis, and Tetanus(DPT)															
(+,*) Diphteria, and Tetanus (Td) or (DT)															
(+,*) Comb. Measles/Mumps/Rubella (MMR)															
Rubeola (Red Measles) live Virus Vaccine															
Rubella (3 day or German Measles)															
Mumps															
Rubeola Titer (attach lab report)															
Rubella Titer (attach lab report)															
Mumps Titer (attach lab report)															
Varicellla Titer (attach lab report)															
Meningicoccal															
Hepatitis A															
Hepatitis B															
(+) TB Skin Test (Mantoux) #1				Results: mm _____											
TB Skin Test (Mantoux) #2				Results: mm _____											

1.Clinical diagnosis of rubeola and mumps is acceptable if verified by physician

Rubeola_____
month day year

Mumps_____
month day year

_____
Physicians Signature

Health Care Provider verifying that immunizations were given.

Name (print) _____ Signature: _____
Address: _____ Date: _____
_____ Telephone: _____
_____

FOR SIUE USE ONLY: Compliant ____Non-Compliant ____ Reviewed by _____ Date_____

Letter sent _____ Hold applied_____ Computer entered_____
Exemptions: Medical ____Religious ____ Age ____ Hold released_____