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SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

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IMMUNIZATION INFORMATION FORM

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

_____ _____ _____
Last Name First Name Middle Initial

_____ _____
SIUE ID number Date of Birth (MM/DD/YY)

First semester at SIUE: **YEAR** _____ Fall _____ Spring _____ Summer _____ International Student: Yes _____ No _____

PART II: IMMUNIZATION INFORMATION
COMPLETE DOCUMENTATION OR ATTACH SIGNED IMMUNIZATIONS

IMMUNIZATIONS REQUIRED BY ILLINOIS LAW (dates required) **Licensed Provider: Complete Immunization documentation or attach signed physician/school immunizations.**		
MEASLES-MUMPS-RUBELLA (MMR or Measles (Rubeola), Mumps, and Rubella) 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967		
☐ MMR	1 mm/dd/yy	2 mm/dd/yy
OR		
☐ Measles (Rubeola)	1 mm/dd/yy	2 mm/dd/yy
☐ Mumps	1 mm/dd/yy	2 mm/dd/yy
☐ Rubella	1 mm/dd/yy	2 mm/dd/yy
Positive serum titers are also acceptable proof of immunity against measles, mumps, and rubella. ☐ Required lab report attached		
TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DT, DTaP, Td, Tdap) A record of THREE (3) tetanus/diphtheria shots with at least one being a Tdap and at least one given within 10 years of enrollment is required.		
1 Td ☐ Tdap ☐ DTP ☐ DTaP ☐ mm/dd/yy	2 Td ☐ Tdap ☐ DTP ☐ DTaP ☐ mm/dd/yy	3 Td ☐ Tdap ☐ DTP ☐ DTaP ☐ mm/dd/yy
MENINGOCOCCAL (Menactra, Menomune, Menveo, Meningococcal ACWY) All new students under the age of 22 must show proof of at least one dose of meningococcal conjugate vaccine on or after their 16th birthday.		
MENACTRA ☐ MENOMUNE ☐ MENVEO ☐ MENINGOCOCCAL ACWY ☐	1 mm/dd/y	2 mm/dd/y
All incoming international students will also need to complete a TB risk assessment. At risk students will be screened with a TB blood test (Quantiferon-gold). This must be completed by the 10th day of class at SIUE Health Service.		

OTHER IMMUNIZATIONS (RECOMMENDED) -- The following are optional immunizations, but are strongly recommended for all students.			
☐ HEPATITIS A	1 mm/dd/yy	2 mm/dd/yy	
☐ HEPATITIS B	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
☐ HPV	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy

Health Care Provider verifying that immunizations were given.

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

FOR SIUE USE ONLY: Compliant _____ Non-Compliant _____ Immunizations Needed (if N/C): _____

Hold Checked _____ Hold Lifted _____ Secure Message _____ Discussed w/Student: In Person or By Phone _____

Exemptions: Medical _____ Religious _____ Age _____ Verified/Entered by: _____ Date: _____

08-2016 This form supersedes all previous forms.