



INSTRUCTIONS FOR COMPLETING THE IMMUNIZATION RECORD FORM

The Illinois Department of Public Health requires that all students attending a post-secondary institution show proof of the following immunizations before registering for classes:

- ❖ **Two doses** of a live **measles** vaccine administered at least one month apart **and** after first birthday
- ❖ **One dose** of a live **rubella** vaccine administered after first birthday
- ❖ **One dose** of a live **mumps** vaccine administered after first birthday
- ❖ **One diphtheria/tetanus (Td)** booster **within ten years of enrollment**

Proof of immunity **or** a diagnosis of measles, mumps, and rubella is also acceptable documentation.

Acceptable documentation must contain the month, day, and year of the vaccine, proof of immunity, or the day the disease was conferred accompanied by a licensed health care provider's signature.

The following exemptions will be granted in lieu of the vaccine if proper documentation is presented along with this form:

- ❖ Medical condition or pregnancy
- ❖ Religious belief
- ❖ Birth date on or before January 01, 1957 (only an exemption for measles, mumps, and rubella)

Helpful tips: If you are having difficulty locating these records, contact your high school. Many state high school health records comply with these immunization requirements.

If you know you have received a particular vaccine but do not have any records of the immunization, a titer blood test can prove your immunity to measles, mumps, and rubella.

If you have questions about the Immunization Record Form, please contact Karen Bryant, Registration & Student Records, at kbryant@erikson.edu or (312) 893-7153. **Please fax the completed form to (312) 893-7168** or mail to:

Erikson Institute
Attn: Karen Bryant
451 North LaSalle Street
Chicago, IL 60654



STUDENT IMMUNIZATION RECORD FORM

Students: Please fill in the top portion with your information. Your health care provider will need to fill in the remainder of the form. You may provide copies of official documentation of the immunization in lieu of a health care provider filling out the form.

Date: _____ Erikson ID Number: _____

Student Name (Last, First, Middle): _____

Date of Birth (month/day/year): _____ Gender: ☐ Male ☐ Female

Semester of first enrollment: ☐ Fall ☐ Spring ☐ Summer Year of first enrollment: _____

Health Care Provider: Please fill in the remainder of the document and return to the student.

1-A: MMR

- | | |
|---|-------------|
| 1. Dose one – immunized on or after first birthday | Date: _____ |
| AND | |
| 2. Dose two – immunized at least 30 days after dose 1 | Date: _____ |

NOTE: If MMR was not given, individual immunizations should be listed below.

1-B: Measles/Mumps/Rubella

Please indicate one of the following options and provide proper documentation.

Measles

- | | |
|---|-------------|
| 1. Immunized with live vaccine on or after first birthday | Date: _____ |
| AND | |
| Immunized with live vaccine at least 30 days after dose 1 | Date: _____ |
| 2. Laboratory evidence of immune titer | Date: _____ |
| 3. Physician diagnosis of disease | Date: _____ |
| 4. Exemption. Please explain: _____ | |

**Mumps**

1. Immunized with live vaccine on or after first birthday Date: _____
AND
Immunized with live vaccine at least 30 days after dose 1 Date: _____
2. Laboratory evidence of immune titer Date: _____
3. Physician diagnosis of disease Date: _____
4. Exemption. Please explain: _____

Rubella

1. Immunized with live vaccine on or after first birthday Date: _____
AND
Immunized with live vaccine at least 30 days after dose 1 Date: _____
2. Laboratory evidence of immune titer Date: _____
3. Physician diagnosis of disease Date: _____
4. Exemption. Please explain: _____

2. Tetanus/Diphtheria

Please indicate one of the following options and provide proper documentation.

1. Booster given within ten years Date: _____
2. Exemption. Please explain: _____

3. Health Care Provider Information

Name of Health Care Provider: _____ Telephone: _____
Signature: _____ Date: _____

For Registration & Student Records Office Use Only

Received by: _____ Date: _____