GOVERNORS STATE UNIVERSITY
Mandatory Student Immunization History

_____ Deadline: Submit by _____

Part I: Submit completed form to *immunizations@govst.edu* or fax to 708.534.1640. Phone: 708.235.7154

Last Name	First	Birth Date mm/dd/yyyy	GSU ID #
			M / F
Phone		Cell	Gender (please circle)

International Student* ☐ Yes ☐ No *Additional immunization requirements apply

Initial semester attending GSU ☐ Spring ☐ Summer ☐ Fall 20_____

PRIVACY RIGHTS WAIVER: I AUTHORIZE Governors State University to release this immunization record to the Illinois Department of Public Health or its designated representative for compliance audits in accordance with Illinois Immunization Law. (Public Act 85-1315) This release also applies in the event of a health or safety emergency.

Student Signature _____ Date _____

Part II: Required immunizations (to be completed by a licensed healthcare provider)

Diphtheria, Tetanus, Pertussis – Combination of 3 or more doses (DTP, DTaP, DT, Td, or TDAP) The last dose of vaccine must be received within the past 10 years. One dose must be TDAP. Tetanus Toxoid (T.T.) NOT acceptable, per state law. A medical note from a Licensed Health Care Provider can be substituted in place of two prior Tetanus dose dates.	Dose 1 ____ / ____ / ____ (mm/dd/yyyy) Dose 2 ____ / ____ / ____ (mm/dd/yyyy) Dose 3 ____ / ____ / ____ (mm/dd/yyyy) **(One Dose must be a Tdap)**
MMR (Measles, Mumps, Rubella) Two doses required, at least one month apart, after 12 months of age AND after 12/31/67.	Dose 1 ____ / ____ / ____ (mm/dd/yyyy) Dose 2 ____ / ____ / ____ (mm/dd/yyyy)

If MMR was not given, individual immunizations or titers should be listed below

Measles (Rubeola)	**Mumps**	**Rubella (German Measles)***
2 doses required. Both must be done on or after 1st birthday and at least 28 days apart. (mm/dd/yyyy) Dose 1 ____ / ____ / ____ Dose 2 ____ / ____ / ____ **OR** Date of Illness ____ / ____ / ____ **OR Attach copy of lab report** (titer) confirming immunity.	2 doses required on or after 1st birthday (mm/dd/yyyy) Dose 1 ___ / ___ / ___ Dose 2 ___ / ___ / ___ **OR** Date of Illness ____ / ____ / ____ **OR Attach copy of lab report** (titer) confirming immunity.	2 doses required on or after 1st birthday (mm/dd/yyyy) Dose 1 ___ / ___ / ___ Dose 2 ___ / ___ / ___ **OR Attach copy of lab report** (titer) confirming immunity. ***Date of illness not accepted for Rubella**

Meningococcal Conjugate/Meningitis Vaccine required for all students born from 1995 to 2000 and vaccine must be given after 16th birthday.

Menactra ☐ Menveo ☐ Other ☐ Dose ____ / ____ / ____ (mm/dd/yyyy)

Part III: <u>Required for International Students Only</u> (to be completed by a licensed healthcare provider)

Tuberculosis Screening Requirement	**Quanti-FERON TB-Gold**	**Tuberculosis Skin Test**
Must be performed within the last 12 months in the United States	Lab test (attach lab report) Date ____ / ____ / ____ Has patient had a history of positive skin test? Yes No Has patient received BCG? Yes No Has patient received INH? Yes No *If "Yes" attach supporting documentation.*	Date: ____ / ____ / ____ Results Negative Positive **Persons with a positive skin test must have further screening with a chest x-ray.**

Part IV: Recommended, but not required (to be completed by a licensed healthcare provider)

Hepatitis B	Dose 1 ____ / ____ / ____	Dose 2 ____ / ____ / ____	Dose 3 ____ / ____ / ____

Licensed healthcare provider's signature and/or electronic signature verifying above information OR records with signature attached verifying information.

Healthcare Provider's Name / Title (print) _____ **Signature** _____ **Date** _____

Address _____ **Phone** _____