GOVERNORS STATE UNIVERSITY
Mandatory Student Immunization History

Spring 2017 **Deadline: Submit by** December 15, 2016

Part I: Submit completed form to *immunizations@govst.edu* or fax to 708.235.3961.

Last Name | First Name | Birth Date (mm/dd/yyyy) | GSU ID #

Phone | Cell | M / F 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 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.	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) 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.	**Mumps** 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.	**Rubella (German Measles)*** 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 16 to 21 years of age.

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

Part III: Required for International Students Only (to be completed by licensed healthcare provider)

Tuberculosis Screening Requirement Must be performed within the last 12 months in the United States	**Quanti-FERON TB-Gold** 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.*	**Tuberculosis Skin Test** 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 licensed healthcare provider)

Hepatitis B	Dose 1 ___/___/___	Dose 2 ___/___/___	Dose 3 ___/___/___
Varicella Vaccine Had Chickenpox	Dose 1 ___/___/___	Dose 2 ___/___/___	**OR Attach copy of lab report** (titer) confirming immunity

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

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

Address **Phone**