GOVERNORS STATE UNIVERSITY
Mandatory Student Immunization History

Summer/Fall 2016 **Deadline: Submit by** September 14, 2016

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

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

Phone | Cell | Sex (please circle) M / F

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 healthcare provider)

Tdap One booster of Tetanus/Diphtheria/Acellular Pertussis within last 10 years. **Tetanus Toxoid (T.T.) NOT acceptable, per state law.**	Booster Dose ____ / ____ / ____ (mm/dd/yyyy)
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** 1 dose required on or after 1st birthday (mm/dd/yyyy) Date ____ / ____ / ____ **OR** Date of Illness ____ / ____ / ____ **OR Attach copy of lab report** (titer) confirming immunity.	**Rubella (German Measles)*** 1 dose required on or after 1st birthday (mm/dd/yyyy) Date ____ / ____ / ____ **OR Attach copy of lab report** (titer) confirming immunity. ***Date of illness not accepted for Rubella**

Meningococcal/Meningitis Vaccine — required if born from 1993 to 2000 and vaccine is given after 16th birthday

☐ Menactra ☐ Menveo ☐ Other Dose ____ / ____ / ____

Part III: Recommended, but Not Required (to be completed by 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

Part IV: Required for International Students Only (to be completed by 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.**
Tetanus/Diptheria Series Additional requirements are required for international students. Must list at least 2 dates from primary series (usually done in childhood) and must be at least 28 days apart	Dose 1 ____ / ____ / ____ (mm/dd/yyyy) Dose 2 ____ / ____ / ____ (mm/dd/yyyy)	

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