

Dear Student:

Here are a few frequently asked questions regarding your immunization records.

Where can I obtain a copy of my immunization records?

- Contact your former High School and have them email or fax us a copy.
- Contact your former 4-year College/University and have them email or fax us a copy. (Note: 2-year Colleges do not require this record)
- Contact your Primary Care Physician and have them email or fax us a copy.

LIST OF REQUIRED IMMUNIZATIONS
T-dap —current within the last 10 years.
MMR (Measles, Mumps, Rubella) 2 doses required after 1 year of age
Meningitis Vaccine — last dose must have been received at age 16 or older— Not necessary for students 22 years and older.

Records can be sent to Wellness Center via:

1. Email at: studenthealth@elmhurst.edu
2. Fax: (630) 617-3255
3. Drop off at the Wellness Center at lower level Niebuhr Hall Room 010
4. Phone: (630) 617-3565

Medical/Immunization History Form can be downloaded by following the directions below:

1. Go to the Elmhurst University website
2. Click on Student Life
3. Click on Health and Wellness
4. Click on Immunization Requirements and Medical History
5. Click on complete Immunization Medical History Form—it is underlined

Please submit the form via mail or fax **no later than June 1 for Fall Semester and December 1 for Spring Semester**

Last Name	First Name	M.I.	Date of Birth (mm/dd/yy)	Student ID (7 digits)
Home Address	City/State/Zip	Country	Gender	Student Cell Phone
Semester and year of first enrollment: Fall (year) _____ Spring (year) _____ Summer (year) _____			Email	

IMMUNIZATION RECORD:

A physical exam is not required. It is an Illinois State Law for all students attending a four-year University and born after 1956 to obtain certain immunizations. You may have your primary care provider, former high-school, or previous college fax your records to the Student Health Service. If you are unable to obtain your immunization dates, you will need to be revaccinated or have an immunity profile (blood test) done to confirm your immunity. Vaccines, TB skin tests, and immunity profiles are available in the Student Health Services for a fee. **All forms must be submitted no later than June 1 for Fall and December 1 for Spring. Students with incomplete immunization records will be put on a "medical hold" and will be unable to register for classes in their second semester.**

REQUIRED IMMUNIZATIONS (Dates Required)

MMR (measles, mumps, rubella)	2 doses of MMR vaccine administered on or after 12 months of age OR positive serum titers to all three diseases (attach lab report)	1. _____ mm/dd/yy	2. _____ mm/dd/yy
MENINGOCOCCAL CONJUGATE VACCINE	Menactra or Menveo is required for all students 21 years of age and younger. NOTE: A 2nd vaccine must be given if the 1st vaccine was given before age 16.	1. _____ mm/dd/yy	2. _____ mm/dd/yy
Tetanus-Diphtheria-Pertussis (DPT, DTP, DT, DTap, Td, Tdap)	Any combination of three or more doses of Tetanus-Diphtheria-Pertussis. One dose must be Tdap. The last dose must be within ten years of the first day of the first semester.		
1. _____ mm/dd/yy	Td Tdap DTP/DTap	2. _____ mm/dd/yy	Td Tdap DTP/DTap
		3. _____ mm/dd/yy	Td Tdap DTP/DTap

RECOMMENDED IMMUNIZATIONS (Complete if received)

HEPATITIS B (Series of 3)	1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy
VARICELLA (Chicken Pox)	1. _____ mm/dd/yy	2. _____ mm/dd/yy	Had Varicella (Chickenpox)

INTERNATIONAL STUDENTS ONLY: Call Student Health Services at (630) 617-3565 for a Tuberculosis Screening when you arrive on campus.

Tuberculosis Skin Test/PPD	1. _____ mm/dd/yy	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive mm induration: _____
----------------------------	----------------------	--

REQUIRED HEALTH CARE PROVIDER INFORMATION

Provider name (print or stamp)	Date
Address	Phone

Please submit the form via mail or fax no later than June 1 for Fall Semester and December 1 for Spring Semester

Last Name	First Name	M.I.	Date of Birth (mm/dd/yy)	Student ID (7 digits)
Home Address	City/State/Zip	Country	Gender	Student Cell Phone

PERSONAL HEALTH HISTORY: Please check all conditions/diseases you have had. If none apply, check this box

General Anemia Autism Spectrum Cerebral Palsy Fatigue Learning Disorder Sleep Issues Weight Gain/Loss (recent) Skin Acne Eczema Skin cancer Psoriasis Head/Ears/Eyes/Nose/Throat Chronic Ear Infections Hearing Impairment Visual Impairment Cardiovascular/Vessel Blood Clotting Disorder Congenital Heart Defect Heart Murmur High Blood Pressure	Respiratory Asthma Bronchitis Pneumonia Gastrointestinal Celiac Disease Crohn's Disease Diverticulosis Dyspepsia (Heartburn) Gallbladder Disease Irritable Bowel Syndrome Ulcerative Colitis Genitourinary/Gyne Hernia Kidney Disease Kidney Stones Menstrual Conditions Urinary tract Infections	Musculoskeletal Arthritis Fibromyalgia Scoliosis Skeletal Disorder Neurological Congenital /Spinal Cord Injury Head Injury/Concussion Headache, recurrent Multiple Sclerosis Seizure Disorder Endocrine Diabetes (PCOS) Polycystic Ovarian Syndrome Thyroid Disorder	Emotional Health Alcohol/Substance Abuse Anxiety/Panic Attacks Attention Deficit (ADD/ADHD) Depression Eating Disorder Mental Health Hospitalization PTSD Suicidal Thoughts Infectious Disease Hepatitis HIV/AIDS Meningitis Tuberculosis Other: _____ _____
--	---	---	---

Surgeries, conditions or hospitalizations not listed above:	None
Routine medications/vitamins/supplements (please list drug, dose and reason):	None
Allergies (please list allergies to medications, foods, environmental or insects):	None

FAMILY HISTORY: Has any immediate family member had any of the following?

Alcohol/Substance Abuse Asthma Cancer Diabetes	Heart Disease High Blood Pressure Kidney Disease Migraine	Mental Health Treatment Seizure Disorder Stroke Sudden Death before age 50	Adopted, History Unknown Other _____
---	--	---	---

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY

Name	Relationship	Phone
Name	Relationship	Phone

Parent Consent for Treatment: All students under 18 years of age enrolled at Elmhurst University must have parental permission before they may receive medical care at Student Health Service. We ask that you sign this statement. I hereby give permission for the medical staff of Elmhurst University Student Health Services to perform diagnostic and therapeutic treatment as they deem necessary.

Signature of parent/guardian of student under 18	Date
--	------