NORTH CENTRAL COLLEGE IMMUNIZATION RECORD

All students are required by North Central College and Illinois Law to submit proof of immunizations. Students born prior to 1/1/1957 are NOT required to submit immunization records. Instead enclose a copy of driver's license or state ID.

PART I

NAME _____ **DATE OF BIRTH** ____/____/_____ **SCHOOL ID#** _____
M D Y

DATE OF ENTRY ____/_____ **STATUS:** Part-time _____ Full-time _____ Graduate _____ Undergraduate _____ Other _____
M Y

PART II: CURRENT IMMUNIZATION REQUIREMENTS, TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. TETANUS, DIPHTHERIA, PERTUSSIS – *Provide dates of any combination of three or more doses of Diphtheria, Tetanus and Pertussis (DTP, DTaP, DT, Td or Tdap)* ***One dose must be Tdap vaccine and must have been received within 10 years prior to the term of current enrollment.***

1. Date of last Tdap: *(must be within 10 years of entrance into North Central College)* ____/____/_____
M D Y

2. List at least 3 dates from primary DTP or DTaP series: #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____
M D Y M D Y M D Y

B. MMR (MEASLES, MUMPS, RUBELLA) *(Two doses required at least 28 days apart for students born after 1956)*

1. Dose 1 given at age 12 months or later #1 ____/____/_____
M D Y

2. Dose 2 given at least 28 days after first dose #2 ____/____/_____
M D Y

3. If dates of immunizations are unknown attach a lab report confirming immunity to Measles, Mumps and Rubella.

C. MENINGOCOCCAL – *Newly admitted students under the age of 22 shall show proof of at least one meningitis vaccine given on or after 16 years of age.*

1. Immunization Dose #1____/____/_____ Dose #2. ____/____/_____
M D Y M D Y

D. TUBERCULOSIS SCREENING REQUIREMENT FOR INTERNATIONAL STUDENTS

A tuberculosis skin test must be done at North Central College in the Dyson Wellness Center prior to the first day of classes. If you have had tuberculosis, bring copies of your medical records with you to campus.

PART III: RECOMMENDED IMMUNIZATIONS, TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

E. HEPATITIS B

1. Immunization Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____
M D Y M D Y M D Y

F. VARICELLA

1.. Immunization Dose #1 ____/____/_____ Dose #2 ____/____/_____
M D Y M D Y

G. POLIO

1. Immunization Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____
M D Y M D Y M D Y

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____) _____