NORTH CENTRAL COLLEGE IMMUNIZATION RECORD

All students registered for classes on campus 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

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 ___/___/_______

M D Y

2. Dose 2 given at least 28 days after first dose ___/___/_______

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

D. TB SCREENING – Newly admitted students are required to complete the attached TB Screening Questionnaire and submit forms prior to the start of classes.

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

F. VARICELLA

1. Immunization Dose #1 ___/___/_______ Dose #2 ___/___/_______

M D Y

G. COVID-19 VACCINE Brand Name of Vaccine ___________________________________________

1. Immunization Dose #1 ___/___/_______ Dose #2 ___/___/_______ Dose #3 ___/___/_______

M D Y

HEALTH CARE PROVIDER

Name __________________________________ Signature _____________________________

Address __________________________________________ Phone (______)_________________