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 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 give on or after 16 years of age.*

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

F. **VARICELLA**

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

G. **COVID-19 VACCINE** Brand Name of Vaccine _____

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

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____)_____

NORTH CENTRAL COLLEGE DYSON WELLNESS CENTER
TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE & TESTING FORM (page 1 of 3)

Name: _____ Student ID#: _____ Date of Birth: _____

Cell Phone: _____

Please refer to this list of countries below when responding to questions #4 through #6

Afghanistan	China, Macao SAR	Haiti	Mozambique	South Africa
Algeria	Colombia	Honduras	Myanmar	South Sudan
Angola	Comoros	India	Namibia	Sri Lanka
Anguilla	Congo	Indonesia	Nauru	Sudan
Argentina	Côte d'Ivoire	Iraq	Nepal	Suriname
Armenia	Democratic People's Republic of Korea	Kazakhstan	Nicaragua	Tajikistan
Azerbaijan	Democratic Republic of the Congo	Kenya	Niger	Thailand
Bangladesh	Djibouti	Kiribati	Nigeria	Timor-Leste
Belarus	Dominican Republic	Kuwait	Northern Mariana Islands	Togo
Belize	Ecuador	Kyrgyzstan	Pakistan	Tokelau
Benin	El Salvador	Lao People's Democratic Republic	Palau	Trinidad and Tobago
Bhutan	Equatorial Guinea	Latvia	Panama	Tunisia
Bolivia (Plurinational State of)	Eritrea	Lesotho	Papua New Guinea	Turkmenistan
Bosnia and Herzegovina	Eswatini	Liberia	Paraguay	Tuvalu
Botswana	Ethiopia	Libya	Peru	Uganda
Brazil	Fiji	Lithuania	Philippines	Ukraine
Brunei Darussalam	French Polynesia	Madagascar	Portugal	United Republic of Tanzania
Bulgaria	Gabon	Malawi	Qatar	Uruguay
Burkina Faso	Gambia	Malaysia	Republic of Korea	Uzbekistan
Burundi	Georgia	Maldives	Republic of Moldova	Vanuatu
Cote d'Ivoire	Ghana	Mali	Romania	Venezuela (Bolivarian Republic of)
Cabo Verde	Greenland	Marshall Islands	Russian Federation	Viet Nam
Cambodia	Guam	Mauritania	Rwanda	Yemen
Cameroon	Guatemala	Mexico	Sao Tome and Principe	Zambia
Central African Republic	Guinea	Micronesia (Federated States of)	Senegal	Zimbabwe
Chad	Guinea-Bissau	Mongolia	Sierra Leone	
China	Guyana	Morocco	Singapore	
China, Hong Kong SAR			Solomon Islands	
			Somalia	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2018. Countries and territories with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

1. Did you ever receive a BCG vaccine as a child?	☐ Yes	☐ No	☐ Unsure
2. Have you ever had close contact with persons known or suspected to have active TB disease?	☐ Yes	☐ No	
3. Have you ever had a history of a positive PPD skin test?	☐ Yes	☐ No	
4. Were you born in one of the countries or territories listed above that have a high incidence of active TB disease? (If yes, please **CIRCLE** the country)	☐ Yes	☐ No	
5. Are you a recent arrival (<5 years) from one of the high prevalence areas listed above? If **YES** please indicate date of arrival: / /	☐ Yes	☐ No	
6. Have you had frequent or prolonged visits (for more than one month) to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, **CHECK** the country/countries)	☐ Yes	☐ No	
7. Have you been a health care worker, volunteer, resident and/or employee of high-risk congregate settings or served clients who are at increased risk of active TB disease (e.g., correctional facilities, long-term care facilities, homeless shelter, substance abuse treatment, rehabilitation facility)?	☐ Yes	☐ No	
8. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low income or abusing drugs or alcohol?	☐ Yes	☐ No	

If the answer to all of the above questions is NO, no further testing is required (no need to complete pages 2 & 3), but you need to submit this questionnaire with your immunization form. The Dyson Wellness Center medical staff will review all forms and has the discretion to require additional testing or treatment as necessary. If the answer is YES to any of the above questions, North Central College requires that you receive TB testing as soon as possible but at least 3-months prior to the start of the semester. You can call the Dyson Wellness Center at (630) 637-5550 or email dysonwellness@noctrl.edu for a consultation with a medical staff member to discuss testing options OR you can have your healthcare provider perform the testing. Then complete and return the Tuberculosis (TB) Risk Assessment on pages 2 and 3 with test results and/or supporting documentation as required.

NORTH CENTRAL COLLEGE DYSON WELLNESS CENTER
TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE & TESTING FORM (page 2 of 3)

Name: _____ Student ID#: _____ Date of Birth: _____

TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by health care provider)

Clinicians should review and verify information on the TB Screening Questionnaire. Persons answering YES to any of the questions are candidates for either Mantoux tuberculin skin test (TST) if getting tested in the United States or Interferon Gamma Release Assay (IGRA), unless a previous positive test is documented.

History of a positive TB skin test or IGRA blood test? No _____ Yes_____ (if Yes, and received previous treatment, complete the TB Symptom Check and the Medication Section)

History of BCG vaccination? (If yes, consider IGRA if possible.) No _____ Yes _____

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1. TB Symptom Check
Does the student have signs or symptoms of active pulmonary tuberculosis disease? No _____ Yes _____

If No, proceed to 2 or 3. If yes, check below:

- ☐ Cough (especially if lasting for 2-3 weeks or longer) with or without sputum production
- ☐ Coughing up blood (hemoptysis)
- ☐ Chest pain
- ☐ Loss of appetite
- ☐ Unexplained weight loss, unusual weakness or extreme fatigue
- ☐ Night sweats
- ☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. **Tuberculin Skin Test (TST) – Recommended for individuals getting tested in the United States ONLY**
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: _____/_____/_____ Date Read: _____/_____/_____
M Day Year M Day Year

Result: _____ mm of induration **Interpretation (please refer to interpretation guidelines): Positive____ Negative_____

(If Positive, Chest X-Ray Required see pg 3 of 3)

**Interpretation guidelines

≥ 5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for 1 month or more)
- HIV-infected persons

≥ 10 mm is positive:

- Recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- Injection drug users
- Mycobacteriology laboratory personnel
- Residents, employees, or volunteers in high-risk congregate settings for example prisons, long term care facilities, health care facilities, homeless shelters, residential facilities for patients with HIV/AIDS
- Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer/hematologic disorders (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.
- Children < than 4 years of age or infants, children and adolescents exposed to adults at high-risk

≥ 15 mm is positive:

- Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

**The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Health Care Provider's Signature: _____(Continue on Page 3)

NORTH CENTRAL COLLEGE DYSON WELLNESS CENTER
TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE & TESTING FORM (page 3 of 3)

Name: _____ Student ID#: _____ Date of Birth: _____

3. Interferon Gamma Release Assay (IGRA) – Recommended for individuals getting tested in any country
Date Obtained: ____/_____/_____ (Specify method) QFT-GIT: _____ T-Spot:_____ Other: _____
M Day Year
Result: Negative: _____ Positive: _____ Indeterminate: _____ Borderline (T-Spot only): _____

4. Chest x-ray: (Required if TST or IGRA is POSITIVE)
Date of chest x-ray: ____/_____/_____ Result: Normal:_____ Abnormal:_____
M Day Year

TUBERCULOSIS (TB) RISK ASSESSMENT: Management of Positive TST or IGRA.

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from latent TB infection to TB disease and should be prioritized to begin treatment as soon as possible.

- ☐ Infected with HIV
- ☐ Recently infected with M. tuberculosis (within the past 2 years)
- ☐ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ☐ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ☐ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ☐ Have had a gastrectomy or jejunoileal bypass
- ☐ Weigh less than 90% of their ideal body weight
- ☐ Cigarette smokers and persons who abuse drugs and/or alcohol

**Populations defined locally as having an increased incidence of disease due to M. tuberculosis, including medically underserved, low income populations.

MEDICATION SECTION:

Was the patient educated and counseled on latent tuberculosis and advised to take medication because of the positive results?
No: _____ Yes: _____

Patient agrees to receive treatment: No: _____ Yes: _____ Patient declines treatment at this time: _____

If yes, what medication(s) was prescribed? _____

Date Started: _____/_____/_____ Date Ended: _____/_____/_____
M Day Year M Day Year

HEALTH CARE PROVIDER

Name (Printed): _____ **Signature:** _____

Date: _____ **Address:** _____

Phone: (_____)_____

Please Return Forms to: **The Dyson Wellness Center**
455 S. Brainard Ave. 2nd floor
Naperville, IL 60540
FAX: (630) 637-5554
immunizations@noctrl.edu

Questions? (630) 637-5550 or immunizations@noctrl.edu