

Immunizations Required	Resident Student	Dates of Administration
Tetanus/Diphtheria/Pertussis, 3 doses required and last dose cannot be more than 10 yrs. old	Required	
Measles (2 doses) OR immunity by lab titre result Diagnosis of disease is not acceptable, lab titre documentation required	Required	
Mumps (1 dose) OR immunity by lab titre result Diagnosis of disease is not acceptable, lab titre documentation required	Required	
Rubella (1 dose) OR immunity by lab titre result Diagnosis of disease is not acceptable, lab titre documentation required	Required	
OR	OR	
MMR (2 doses) of Measles, Mumps and Rubella	Required	
Meningitis/one given over the age of 16	Required	

Health Care Provider Signature

Telephone Number

Date

Upon arrival at the University of St. Francis in Joliet, IL a physical exam will be performed by one of our Nurse Practitioners and a tuberculin skin test will be given by the staff at our Wellness Center.

IMMUNIZATION HISTORY

Name _____ Date of Birth _____

PLEASE READ CAREFULLY: Illinois law requires incoming students born on or after January 1, 1957 to document proof of immunity to measles, rubella, mumps and tetanus/diphtheria. This may be done by one of the following methods:

- 1) Attach a copy of the student's Certificate of Child Health Examination (obtain from high school health records).
- 2) Provide comparable documentation from prior college or university.
- 3) Provide verification of immunizations taken from the doctor's (MD or DO) records or other health care provider.

IMMUNIZATION: Please provide the month, day, and year for dose administered. The day and month is required if you cannot determine if the vaccine was given prior to the minimum interval or age.

	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
TETANUS/DIPHTHERIA) (within last 10 years)					
DIPHTHERIA/TETANUS/PERTUSSIS, if International Student , 3 doses required*					
MEASLES (2 doses) OR immunity by lab titre OR confirmed diagnosis					
MUMPS (1 dose) OR immunity by lab titre OR confirmed diagnosis					
Rubella (1 dose) OR immunity by lab titre. Diagnosis of disease is not acceptable.					
OR					
MMR (2 doses) of Measles, Mumps and Rubella					
TB skin test (Mantoux)	Date 1 st test	Result mm	Date 2 nd test	Result mm	Chest x-ray date Result
Varicella/Chickenpox (2 doses) or immunity by lab titre. Diagnosis of disease is not acceptable.					
Hepatitis B (3 doses)					

**Please return all completed forms to Health Services,
Room 232 Motherhouse or return in enclosed envelope.**

STUDENT PROFILE

Please check all that apply:

☐ College of Nursing/Allied Health	☐ Resident	☐ Commuter
Name _____		SSN# _____
Las _____	Fi _____	M.I. (Maile) _____
Place of Birth: State/City _____		Date of Birth _____
Student Address _____		Home Telephone _____
_____		Work Telephone _____
Parent's Name _____		Relationship _____
Address _____		
(Street) _____	(City) _____	(State) _____ (Zip) _____
E-mail _____		Telephone _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____	Name _____
Relationship _____	Relationship _____
Address _____	Address _____
Telephone _____	Telephone _____
Physician Name _____	Physician Telephone _____
Physician Address _____	

Health Insurance Carrier _____

3ROLFR0GHUWDPHSDUHQVSRXM _____

Play# _____ G# _____

Is the student a Health Maintenance Organization (HMO)? Yes _____ No _____

Does the student have a primary care physician? Yes _____ No _____

Designate _____

HSDm

56Fm

5632

500 NY

560435

Name _____

1. If yes to any questions on page one, explain thoroughly including dates and treatment:

2. Do you have any current restrictions related to above history? ____ Yes ____ No. If yes, explain:
specifically: _____

3. Have you ever had to change occupations for health reasons? ____ Yes ____ No. If yes, explain:

4. Are you currently using any tobacco products? ____ Yes ____ No. If yes, explain:

5. What medications (prescription and non-prescription) do you currently take? Please list.

MDCAIRAE -CONFIRM

In the event a student at the University of St. Francis needs emergency medical treatment, a hospital will not
DGPLQLVWHU WUHDWPHQW ZLWKRXW WKH H[SUHVVHG SHULRGLRQ RI
sending this form to obtain your permission to act in your behalf in the event of any medical emergency.

Please check one:

_____ I do give the University of St. Francis permission to act in my behalf with regard to providing emergency hospital or clinic

PHYSICIAN

NO

*~~PHYSICIAN~~

, ~~PHYSICIAN~~

~~PHYSICIAN~~

Example: ~~PHYSICIAN~~

~~PHYSICIAN~~ ~~PHYSICIAN~~ ~~PHYSICIAN~~

Name _____ Date _____

Height. _____ Weight. _____ B/P _____ P _____ R _____

A. ~~PHYSICIAN~~ ~~PHYSICIAN~~ ~~PHYSICIAN~~

Health Record Submission