

LINCOLN COLLEGE IMMUNIZATION REPORT

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DO NOT WRITE IN AREA BELOW:

FOR LINCOLN COLLEGE HEALTH SERVICE ONLY

Information Complete

Complete Data Entered in Computer

To be completed in BLACK INK - please PRINT

Name—Last		First	Middle	Maiden	ID Number
Date of Birth (MM/DDYY)	Age	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Citizenship (specify) <input type="checkbox"/> U.S. <input type="checkbox"/> Other	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date Entering LC (MM/YY)

Home Address _____ Cell Phone () _____
City/State/Zip _____ Home Phone () _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name _____ Relationship _____
Address _____ City/State/Zip _____
Phone () _____ (Home) () _____ (Work)
Cell Phone () _____ Pager () _____

IMMUNIZATION & VERIFICATION INFORMATION

ALL IMMUNIZATION DATES AND PROOF OF FREEDOM FROM TB MUST BE VERIFIED BY A PHYSICIAN OR PUBLIC HEALTH OFFICIAL WITH FULL NAME, SIGNATURE, PROFESSIONAL TITLE AND COMPLETE ADDRESS AND PHONE NUMBER.

Any student not in compliance with immunization requirements during the first semester of attendance at Lincoln College WILL NOT BE ALLOWED TO REGISTER for a subsequent semester until he/she is in compliance.

A. REQUIRED IMMUNIZATION INFORMATION

DIPHTHERIA - PERTUSSIS - TETANUS (DPT OR baby shots)	1	2	3	4	
TETANUS DIPHTHERIA (Td - within 10 yrs. of attendance, every 10 yrs as adult)	1	2			
MMR	1	2			
MEASLES (hard, red, 10 day) - 2 doses after 12 months and after 12/31/65	1	2	OR date disease diagnosed & doctor's signature OR blood titer with copy of lab report attached		
MUMPS - after 12 months and after 12/31/67	1		OR date disease diagnosed & doctor's signature OR blood titer with copy of lab report attached.		
RUBELLA (3 day, German) - after 12 months and after 12/31/65	1		OR blood titer with copy of lab report attached History of Rubella disease NOT ACCEPTABLE		

B. TUBERCULOSIS INFORMATION - IF REQUESTED

TB Skin Test (Mantoux) *Dates for test should be within one year of attendance and must have been given in the United States.*

Date given _____ Date read _____ Results _____ (record in millimeters)

If indicated - Chest x-ray results/date _____ (Please attach copy of x-ray report)

Previous treatment / preventive therapy for TB: Y N If yes, give dates, medication taken and for how long, and attach physician's summary of current status.

C. RECOMMENDED IMMUNIZATION INFORMATION - NOT REQUIRED FOR ATTENDANCE AT LINCOLN COLLEGE.

HEPATITIS B	1	2	3
HEPATITIS A	1	2	
CHICKENPOX	1	2	
MENINGOCOCCAL VACCINE	1		

PHYSICIAN OR PUBLIC HEALTH OFFICIAL VERIFICATION

I verify to the best of my knowledge that the above immunization and TB test information is correct.

Physician Name (print or stamp)	Signature	Date
Address		Phone ()

STUDENT VERIFICATION AND AUTHORIZATION

I certify that the above information is complete and correct to the best of my knowledge, and I authorize the Illinois Department of Public Health to review my immunization record. I authorize Lincoln College Health Service to give me reasonable and proper medical care by today's standards.

Signature of Student _____

Date _____