



# Lincoln College Immunization Form

300 Keokuk Street, Lincoln, IL 62656 Phone: (217) 732-3155 Fax: (217) 735-5214

||||| THIS IS NOT A PHYSICAL FORM |||||

1. \_\_\_\_\_  
Last Name First Name Initial Maiden

Street Address City State Zip Code

2. Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

**Statement by the student:** I authorize Lincoln College to release this immunization information to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

**This requirement may be met in one of these ways.** Please indicate which way.

- 1. Have a physician complete this form.
- 2. Submit public school health records signed by a physician or nurse. Military records are also applicable.
- 3. Attach a copy of immunization records with a physician's signature or clinic stamp.

### 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)	1	2	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 date disease diagnosed & doctor's signature OR blood titer with copy lab report attached.			
Mumps	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 \_\_\_\_\_