

Full Legal Name \_\_\_\_\_  
last middle first maiden

Home Address \_\_\_\_\_  
street city state zip code

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Cell Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Date Entering LCN \_\_\_\_\_  
mm/dd/yy mm/dd/yy mm/yy

Gender  Male  Female U.S. Citizen  Yes  No  
 Student Signature (authorizes Illinois Department of Health to review immunization record) \_\_\_\_\_

All immunization dates must be verified by a physician or public health official with full name, signature, professional title and complete address and phone number. Students may also attach the Illinois School Certificate of Child Health (which can be obtained from a high school) or use other certified immunization records. Students not in compliance by the end of the first session of attendance will not be allowed to register for subsequent sessions until in compliance.

**Required Immunization Information**

|                                                                                                      | 1. | 2. | 3.                                   | 4. |
|------------------------------------------------------------------------------------------------------|----|----|--------------------------------------|----|
| Diphtheria-Pertussis - Tetanus (DPT or DTaP, DT)**                                                   |    |    |                                      |    |
| Diphtheria-Tetanus (Td - within 10 years of attendance)<br>Tetanus Toxoid not acceptable             | 1. |    |                                      |    |
| MMR (Measles/Mumps/Rubella)                                                                          | 1. | 2. |                                      |    |
| Measles (hard, red, 10-day - two doses after 12 months)<br>OR date diagnosed by physician Date _____ | 1. | 2. | or Measles titer - attach lab report |    |
| Mumps (one dose after 12 months)<br>OR date disease diagnosed by physician Date _____                | 1. |    | or Mumps titer - attach lab report   |    |
| Rubella (3 day, German - one dose after 12 months)<br>History of disease not acceptable              | 1. |    | or Rubella titer - attach lab report |    |

**Recommended Immunization Information (not required for attendance)**

|                         | 1. | 2. | 3. |
|-------------------------|----|----|----|
| Hepatitis B             |    |    |    |
| Meningococcal Vaccine   | 1. |    |    |
| Chicken Pox (Varicella) | 1. | 2. |    |

\*\*International Students are required to provide dates of any combination of three or more doses of DPT or DTaP, or TD vaccine, with the most recent dose having been received within 10 years prior to current enrollment.

**Physician or Public Health Official Verification**

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

Name (print or stamp) \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip code

Phone \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

**FOR OFFICE USE ONLY**

Immune  Yes  No

Status  Complete  Incomplete

|      |
|------|
| Td   |
| M1   |
| M2   |
| MU   |
| RUB  |
| HEPB |
| CP   |
| MEN  |

Exemption  Medical  Religious  Temporary, extend to: \_\_\_\_\_

Reviewed by: \_\_\_\_\_  
 Date reviewed: \_\_\_\_\_  
 Dated entered into Jenzabar: \_\_\_\_\_  
 Student ID Number: \_\_\_\_\_

Immunization forms may be mailed or faxed to the following:  
 Attn: Immunization, 715 W. Raab Road, Normal, IL 61761  
 Fax: (309) 454-5652