Lake Forest College Immunization Record Form

All full-time and half-time students are required by Lake Forest College and Illinois law to submit proof of immunization.

THIS PAGE MUST BE COMPLETED BY A HEALTHCARE PROVIDER and include their name (printed), signature and date at the bottom, to be considered valid under Illinois State Law.

All records must be submitted in English. A translation by a certified translator with copies of the original records is acceptable.

An original immunization record from your medical provider may be submitted in place of this page.

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

REQUIRED IMMUNIZATIONS	DATE ADMINISTERED
Tetanus/Diphtheria/Pertussis: • Any combination of *three or more doses* of vaccines containing Diphtheria, Tetanus, and Pertussis • One dose must be a Tdap vaccine. • The last dose of vaccine (DTP, DTaP, DT, Td, or Tdap) must have been received *within 10 years prior to the term of current enrollment*.	**Primary Series:** (1)_____ /_____ /_____ (2)____ /_____ /_____ (DTaP/DTP) **Tdap Booster:** _____ /_____ /_____ (last dose must be within 10 years)
Measles, Mumps, Rubella (MMR) • Two doses each of live measles, mumps and rubella virus vaccine(s) *on or after the first birthday* • Minimum time interval between each dose must have been at least 28 days • If proof of immunization cannot be provided, serologic evidence of immunity in the form of antibody titer tests may be provided.	**Combined MMR:** (1) _____ /_____ /_____ (2) _____ /_____ /_____ **OR** **Measles**: (1) _____ /_____ /_____ (2) _____ /_____ /_____ **Mumps:** (1) _____ /_____ /_____ (2) _____ /_____ /_____ **Rubella**: (1) _____ /_____ /_____ (2) _____ /_____ /_____ **OR** <u>Titers Indicating Positive Immunity</u> **Measles**: (1) _____ /_____ /_____ (2) _____ /_____ /_____ **Mumps**: (1) _____ /_____ /_____ (2) _____ /_____ /_____ **Rubella**: (1) _____ /_____ /_____ (2) _____ /_____ /_____
Meningococcal Conjugate • Must cover serogroups A, C, W & Y • If under the age of 22, at least one dose of meningococcal conjugate vaccine *on or after 16 years of age* • If 22 years or older, not required	**Meningococcal Conjugate:** _____ /_____ /_____ (Dose must be on or after 16th birthday)

HEALTHCARE PROVIDER

Name and Title of Healthcare Provider (Printed):_____

Signature of Provider: _____ Date: _____/_____/_____

Provider Stamp