Lake Forest College Immunization Record

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 (e.g. M.D., D.O., or Licensed Nurse), 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: ______________________ **Student ID:**______________ **Date of Birth:** ______________

I. REQUIRED IMMUNIZATIONS	DATE ADMINISTERED (MM/DD/YY)
Tetanus/Diphtheria/Pertussis: Any combination of 3 or more doses of Diphtheria, Tetanus and Pertussis containing vaccine (DTP, DTap, Tdap)	**Primary Series: (1)**___/___/___**(2)**___/___/___ **Tdap Booster**:_____/_____/_____ (last booster must be within 10 years)
Measles, Mumps, Rubella (MMR): 2 doses required at least 1 month apart with first dose being 12 months of age.	**(1)**_____/_____/_____**(2)**_____/_____/_____**OR** titer indicating positive immunity____/___/___
OR ALL 3 OF THESE CRITERIA ARE MET:	
Measles (Rubeola)	**(1)**_____/_____/_____**(2)**_____/_____/_____**OR** titer indicating positive immunity____/___/___
Mumps	**(1)**_____/_____/_____**(2)**_____/_____/_____**OR** titer indicating positive immunity___/___/___
Rubella (German Measles)	**(1)**_____/_____/_____**(2)**_____/_____/_____**OR** titer indicating positive immunity___/___/_____
Meningococcal Conjugate: Required **ONLY** for students age 22 years or younger at the start of classes. MUST have been completed at 16 years of age or older.	**(1)** ____/_____/_______

II. STRONGLY RECOMMENDED	DATE ADMINISTERED (MM/DD/YY)
Hepatitis A 2 or 3 doses	**(1)**___/___/___**(2)**___/___/___ **(3)**___/___/___
Hepatitis B 3 doses	**(1)**___/___/___**(2)**___/___/___**(3)**___/___/___
Meningococcal B **2 or 3 doses**	**(1)**___/___/___**(2)**___/___/___**(3)**___/___/___
Human Papillomavirus (HPV) : **3 doses**	**1)**___/___/___ **(2)**___/___/___ **(3)**___/___/___

III. TUBERCULOSIS	DATE ADMINISTERED (MM/DD/YY)
Complete Tuberculosis Self-Screening on page 3 to determine if tests are needed. If your answers to the Tuberculosis Self-Screening instruct you to complete a TB test and you complete a PPD skin test, record the result here.	**Date Placed:**____/____/____ **Date Read:**____/____/____ **Result:** ________ (millimeters)* *If result is >= 5mm, please reach out to Health & Wellness Center for additional requirements.

IV. HEALTHCARE PROVIDER

Name and title of Provider (printed): ____

Signature of Provider: _________________________________ **Date:** ___/___/______

Address: ____

Phone Number: (_____)____________________

Exemptions: If you feel that you are exempt from vaccination requirements based on a medical contradiction, religious beliefs, or pregnancy, please contact the Health and Wellness Center at Lake Forest College at 847-735-5240 to discuss the necessary procedures and documentation.