



IMMUNIZATION FORM FOR NON-MEDICAL STUDENTS - 2022-23

LAST NAME:	FIRST NAME:	MI:
STUDENT ID (8-DIGITS):	DATE OF BIRTH:	SEX AT BIRTH: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
PHONE NUMBER:	E-MAIL:	
FIRST QUARTER ATTENDING: <input type="checkbox"/> AUTUMN <input type="checkbox"/> WINTER <input type="checkbox"/> SPRING <input type="checkbox"/> SUMMER		

>>>> PROOF OF COVID-19 VACCINE SHOULD BE UPLOADED TO [MY.WELLNESSPORTAL](https://my.wellnessportal.uchicago.edu) <<<<

BELOW SECTIONS TO BE COMPLETED BY A HEALTHCARE PROVIDER. DATES SHOULD BE FORMATTED AS MM/DD/YYYY.

REQUIRED VACCINES	MMR (COMBINED MEASLES, MUMPS, RUBELLA) - 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW. - STUDENTS BORN ON OR BEFORE 1/1/57 DO NOT HAVE PROVIDE IMMUNITY FOR MMR.	DOSE #1 DATE (ON OR AFTER FIRST BIRTHDAY & AFTER 1/1/68):	DOSE #2 DATE (AT LEAST 28 DAYS AFTER FIRST MMR DOSE):	
	OR PROVIDE THE FOLLOWING:			
	Measles (Rubeola) 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AFTER 1/1/68, AND AT LEAST 28 DAYS APART.	DOSE #1 DATE:	DOSE #2 DATE:	OR ATTACH COPY OF LAB REPORT (TITER) CONFIRMING IMMUNITY (ANTIBODIES)
	Mumps 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AND AT LEAST 28 DAYS APART.	DOSE #1 DATE:	DOSE #2 DATE:	OR ATTACH COPY OF LAB REPORT (TITER) CONFIRMING IMMUNITY (ANTIBODIES)
	Rubella (German Measles) 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AND AT LEAST 28 DAYS APART.	DOSE #1 DATE:	DOSE #2 DATE:	OR ATTACH COPY OF LAB REPORT (TITER) CONFIRMING IMMUNITY (ANTIBODIES)
	Tetanus/Diphtheria/Pertussis 3 DOSES OF DTP, DPT, DTaP, DT, Td, OR Tdap ARE REQUIRED. - ONE DOSE MUST BE Tdap . - THE FIRST TWO DOSES MUST BE AT LEAST 28 DAYS APART. - LAST DOSE MUST HAVE BEEN RECEIVED WITHIN 10 YEARS PRIOR TO THE TERM OF CURRENT ENROLLMENT. - TETANUS TOXOID IS NOT ACCEPTABLE IN FULFILLING THIS REQUIREMENT.			
Tdap DATE:	DTP, DPT, DTaP, TD, DT, OR Tdap DATE: (PLEASE CIRCLE THE TYPE OF DOSE)	DTP, DPT, DTaP, TD, DT, OR Tdap DATE: (PLEASE CIRCLE THE TYPE OF DOSE)		
Meningococcal Conjugate - REQUIRED FOR ALL NEW STUDENTS UNDER THE AGE OF 22. - ONE DOSE MUST HAVE BEEN GIVEN ON OR AFTER 16 TH BIRTHDAY.			VACCINE DATE:	

SIGNATURE OF HEALTH PROVIDER **SIGNING PROVIDER IS VERIFYING ALL DATES ARE ACCURATE** DATE

HEALTHCARE PROVIDER NAME (PLEASE PRINT OR USE CLINIC STAMP)

ADDRESS

TELEPHONE NUMBER

FAX NUMBER