UChicago Student Wellness

IMMUNIZATION FORM FOR MEDICAL STUDENTS 2021-22

LAST NAME:	FIRST NAME:	MI:
STUDENT ID (8-DIGITS):	DATE OF BIRTH:	SEX: ☐ FEMALE ☐ MALE
PHONE NUMBER:	UCHICAGO E-MAIL:	
FIRST QUARTER ATTENDING: ☐ AUTUMN ☐ WINTER ☐ SPRING ☐ SUMMER	YEAR:	

>>>> PROOF OF COVID-19 VACCINE SHOULD BE UPLOADED TO MY.WELLNESSPORTAL <<<<

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	DOSE #1 DATE (ON OR AFTER FIRST BIRTHDAY & AFTER 1/1/68):	DOSE #2 DATE (AT LEAST 28 DAYS AFTER FIRST MMR DOSE):	**AND** MUST PROVIDE DATE OF BLOOD TITER FOR MEASLES, MUMPS, AND RUBELLA; RESULTS; AND COPY OF LAB TEST. PLEASE COMPLETE THE BELOW FIELDS.
OR PROVIDE THE FOLLOWING:			
Measles (Rubeola) - 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AND AT LEAST 28 DAYS APART. - MUST PROVIDE DATE OF BLOOD TITER, RESULTS, AND COPY OF LAB TEST.	DOSE #1 DATE:	DOSE #2 DATE:	BLOOD TITER DATE: RESULT: ☐ ATTACHED COPY OF LAB TEST IN ENGLISH
Mumps - 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AND AT LEAST 28 DAYS APART. - MUST PROVIDE DATE OF BLOOD TITER, RESULTS, AND COPY OF LAB TEST.	DOSE #1 DATE:	DOSE #2 DATE:	BLOOD TITER DATE: RESULT: ☐ ATTACHED COPY OF LAB TEST IN ENGLISH
Rubella (German Measles) - 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AND AT LEAST 28 DAYS APART. - MUST PROVIDE DATE OF BLOOD TITER, RESULTS, AND COPY OF LAB TEST.	DOSE #1 DATE:	DOSE #2 DATE:	BLOOD TITER DATE: RESULT: ☐ ATTACHED COPY OF LAB TEST IN ENGLISH

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)

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REQUIRED VACCINES

Hepatitis B - THREE DOSES GIVEN AT 0, 1-2, AND 4-6 MONTHS. - BLOOD TITER TEST MAY BE COMPLETED DURING FIRST QUARTER	DOSE #1 DATE:	DOSE #2 DATE:	DOSE #3 DATE:	*ANTIBODY* BLOOD TITER DATE: RESULT: ☐ ATTACHED COPY OF LAB TEST IN ENGLISH
Varicella (Chicken Pox) - MUST PROVIDE BLOOD TITER, **OR** - DATES OF VACCINES IF YOU HAVE NOT HAD CHICKEN POX	DOSE #1 DATE:	DOSE #2 DATE:	OR	BLOOD TITER DATE: RESULT: ☐ ATTACHED COPY OF LAB TEST IN ENGLISH
Meningococcal Conjugate - REQUIRED FOR ALL NEW STUDENTS UNDER THE AGE OF 22. - ONE DOSE MUST HAVE BEEN GIVEN ON OR AFTER 16TH BIRTHDAY.				VACCINE DATE:

COMPLETE ONE OF THE BELOW. DATES SHOULD BE FORMATTED AS MM/DD/YYYY.

TUBERCULOSIS

Tuberculin Skin Test (Mantoux Only) TO BE COMPLETED WITHIN 3 MONTHS OF start of classes	PLACEMENT DATE:	READ DATE:	RESULT: _____ MM INDURATION (IF NO INDURATION, RECORD 0)
OR PROVIDE THE FOLLOWING:			
Chest X-Ray IF STUDENT HAS A HISTORY OF A POSITIVE TB SKIN TEST OR TREATED TB DISEASE (MUST BE DONE IN THE USA WITHIN 1 YEAR OF REGISTRATION.	CHEST X-RAY DATE: ☐ ATTACHED COPY OF CHEST X-RAY REPORT IN ENGLISH		QUANTIFERON GOLD/T-SPOT TEST DATE: RESULT: ☐ ATTACHED COPY OF LAB TEST IN ENGLISH

SIGNTURE OF HEALTHCARE PROVIDER DATE

HEALTHCARE PROVIDER NAME (PRINT) ADDRESS

TELEPHONE NUMBER FAX NUMBER

CLINIC STAMP:

SIGNING PROVIDER IS VERIFYING ALL DATES ARE ACCURATE

The University of Chicago
Student Wellness Center, 840 East 59th Street, Chicago, Illinois 60637 773.834.WELL wellness.uchicago.edu