UChicago Student Wellness

IMMUNIZATION FORM FOR NON-MEDICAL STUDENTS - 2023-24

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

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 16TH BIRTHDAY.		VACCINE DATE:	

SIGNTURE 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

The University of Chicago
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