UIC DENTISTRY

Clinical Administration
801 S. Paulina Room 301
Chicago, IL 60612

MANDATORY MEDICAL IMMUNIZATION DOCUMENTATION FORM

PART I: To be completed by the Student/Employee (Please Print)

_____ _____ _____/_____/_____
Last Name *First* *Middle Initial* *UIN (If assigned)* *Date of Birth*

_____ _____ _____
Address (Number and Street) *City and State* *Zip Code*

(_____)_____ ___M___F___ _____ _____
Home Telephone Number Sex *E-mail Address* Year of Admission

I authorize the University of Illinois at Chicago to release this immunization record to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Signature_____

PART II: To be completed and signed by a healthcare provider. All dates must include month, day, and year. All required titer results

MEASLES (RUBEOLA) ***** *Attach copy of laboratory report*

☐ Immunization Confirmed with blood titer

Date of titer::_____/_____/_____ Result:_____

☐ Date of re-immunization::_____/_____/_____

RUBELLA (GERMAN MEASLES)* *Attach copy of lab report*

☐ Immunization Confirmed with blood titer

Date of titer::_____/_____/_____ Result:_____

☐ Date of re-immunization::_____/_____/_____

MUMPS ***** *Attach copy of laboratory report*

☐ Immunization Confirmed with blood titer

Date of titer::_____/_____/_____ Result:_____

☐ Date of re-immunization::_____/_____/_____

TETANUS & DIPHTHERIA (TD, DT or DPT)

**Tetanus Toxoid (TT) is NOT acceptable*

Three immunizations are needed OR date of last booster OR date of adult immunization:

☐ Immunization 1 Date _____/_____/_____

☐ Immunization 2 Date _____/_____/_____

☐ Immunization 3 Date _____/_____/_____

OR

☐ Last Booster Date::_____/_____/_____

OR

☐ Immunization as an adult Date:_____/_____/_____

POLIO (Polio Immunization is *NOT required for College of Dentistry Healthcare Providers but* ***IT IS A REQUIREMENT FOR STUDENTS***)

(At least three doses of inactivated polio vaccine (IPV), live oral poliovirus vaccine (OPV), or four doses of any combination of IPV/OPV.

☐ Primary Series Completed:

Immunization 1 Date: ____/____/_____ ☐ Oral ☐ Injection

Immunization 2 Date: ____/____/_____ ☐ Oral ☐ Injection

Immunization 3 Date: ____/____/_____ ☐ Oral ☐ Injection

Last Booster Date: _____/_____/_____ ☐ Oral ☐ Injection

☐ Immunization as an adult Date:_____/_____/_____

OR

☐ Immunization confirmed by **titer** Date:_____/_____/_____

VARICELLA ZOSTER (CHICKEN POX) ***Attach copy of lab report*

☐ Immunization Confirmed with blood titer

Date of titer::_____/_____/_____ Result:_____

☐ Date of re-immunization::_____/_____/_____

TUBERCULOSIS

☐ Quantiferon Gold date _____/_____/_____ Results _____

If positive test result then a baseline Chest x-ray is required:

☐ Date of x-ray:_____/_____/_____ ☐ Positive ☐ Negative

☐ Had BCG vaccine. Date :_____/_____/_____

NOTE: History of BCG vaccine does not exempt from TB Testing.

FLU VACCINE date _____/_____/_____

HEPATITIS B * *Attach copy of laboratory report*

Three immunizations are needed and proof of immunity by titer.

☐ Immunization 1 Date _____/_____/_____

☐ Immunization 2 Date _____/_____/_____

☐ Immunization 3 Date _____/_____/_____

AND

☐ Immunization confirmed by titer date:_____/_____/_____

HB surface antigen ☐ Positive ☐ Negative

HB surface antibody ☐ Positive ☐ Negative

Antibody must be positive or immunization is required

MEDICAL EXEMPTIONS

☐ Attach physician's statement of medical contraindications with duration of medical condition.

CERTIFICATION BY HEALTH CARE PROFESSIONAL

_____ Circle: RN MD DO Other____

Name of Health Care Provider completing form

Name and address of Institution or Clinic (or stamp)

Phone (_____)_____ Fax (_____)_____

I certify that this information is complete and correct to the best of my knowledge.

Signature_____ Date:_____/_____/_____

Revised 03/2010