

Last Name		First	Middle	University Identification Number	
Home Address/City/State/Country/Zip or Postal Code				Preferred Phone ()	Alternate Phone ()
				E-mail Address	
Date of Birth (mm/dd/yyyy)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Enrollment term/year FA__ SP__ SU__	Citizenship <input type="checkbox"/> U.S. <input type="checkbox"/> Other	
Person to Notify in an Emergency Name:			Relationship	Contact Phone ()	
Address of Emergency Contact (including City/State/Country/Zip or Postal Code)				Alternate Phone ()	

↓ ↓ ↓ This section must be completed by a Licensed Health Care Provider. ↓ ↓ ↓

REQUIRED IMMUNIZATIONS (dates required)

Licensed Provider: Complete Immunization documentation or attach signed physician/school immunizations.

■ **MEASLES-MUMPS-RUBELLA** – 2 shots against Measles, 2 shots against Rubella, and 2 shots against Mumps. Given at least 28 days apart, after 12 months of age and both doses given after 12/31/1967. Documentation of dates of disease **IS NOT** acceptable evidence of immunity against Measles, Mumps or Rubella. **Individuals born before 1957 are exempt from MMR vaccine documentation.

MMR (strongly recommended) **	1 mm/dd/yy	OR	Positive serum titers are also acceptable proof of immunity against Measles, Mumps and Rubella. <input type="checkbox"/> Required lab report attached.
	2 mm/dd/yy		

MEASLES (Rubeola)	1 mm/dd/yy	MUMPS	1 mm/dd/yy	RUBELLA	1 mm/dd/yy
	2 mm/dd/yy		2 mm/dd/yy		2 mm/dd/yy

■ **MENINGOCOCCAL CONJUGATE VACCINE (MENACWY)** Students between the ages of 16-21 must have one dose of Menactra, MenQuadfi, Menveo, Nimenrix or Aramen on or after their 16th birthday. Students age 22 and over are not required to receive the vaccine. **Meningococcal-B vaccine does not meet this requirement.**

☐ Menactra/Menveo/MenQuadfi mm/dd/yy ☐ Other: Vaccine name mm/dd/yy

■ **TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DT, DTaP, Td, Tdap) –**

At least 3 doses of diphtheria, tetanus and pertussis containing vaccine are **REQUIRED**. One dose **MUST** be Tdap.

The last dose of vaccine (DPT, DTP, DT, DTaP, Td, Tdap) must have been administered within 10 years of the student's enrollment date.

1 (record first shot here) <input type="checkbox"/> DTP / DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy	2 <input type="checkbox"/> DTP / DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy	3 <input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy
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RECOMMENDED IMMUNIZATIONS (complete if received)

<input type="checkbox"/> COVID-19 Acceptable brands may include: Pfizer Moderna J&J Other-list	1 mm/dd/yy	2 mm/dd/yy	Booster Vaccine Name mm/dd/yy Booster Vaccine Name mm/dd/yy
<input type="checkbox"/> HEPATITIS A	1 mm/dd/yy	2 mm/dd/yy	
<input type="checkbox"/> HEPATITIS B	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
<input type="checkbox"/> HPV (Gardasil) <input type="checkbox"/> HPV (Cervarix)	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
<input type="checkbox"/> MENINGITIS B <input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
<input type="checkbox"/> VARICELLA	1 mm/dd/yy	2 mm/dd/yy	<input type="checkbox"/> Had Varicella (Chickenpox)

Required Healthcare Provider Verification: Vaccine dates must be on or prior to provider verification date.

Provider Name (print or stamp)	Signature	Date
Address		Phone

TO SUBMIT FORM: Students: Upload to MyMcKinley.illinois.edu **Providers:** Fax or Mail to McKinley Health Center
Submission Deadlines: Fall - July 1, Spring - December 1, Summer - April 1