Name. _____ SS#. _____ Date of Birth: _____

PART IV—REQUIRED IMMUNIZATIONS AND TUBERCULOSIS SCREENING/TESTING

Your healthcare provider must complete *Parts III & IV in English* (including any attached reports) and sign at the end of the section for the information to be valid under Illinois law. Vaccine requirements may be different in your state or country.

THE FOLLOWING ITEMS ARE REQUIRED FOR ALL STUDENTS:

MEASLES (Rubeola): One of the following is required.

1. 2 doses of **live** attenuated virus given on or after the **1st** birthday, at least **28** days apart, and after **1-1-68** — Date of dose #1. _____ Date of dose #2. _____
or 2. Confirmation by physician's records of disease history and date of conclusive diagnosis — Date of illness. _____
or 3. Positive measles serology **(Must attach a copy of laboratory report in English.)**

MUMPS: One of the following is required.

1. 1 dose of **live** attenuated virus given on or after the **1st** birthday and after **1-1-68.** — Date of dose. _____
or 2. Confirmation by physician's records of disease history and date of conclusive diagnosis — Date illness. _____
or 3. Positive mumps serology **(Must attach a copy of laboratory report in English.)**

RUBELLA (German Measles): One of the following is required.

1. Receipt of **1** dose of **live** rubella vaccine on or after the **1st** birthday and after **1-1-69** — Date of dose. _____
or 2. Positive rubella serology **(Must attach a copy of laboratory report in English.)**

TETANUS/DIPHTHERIA: Complete **1 and 2** for **INTERNATIONAL STUDENTS**. Complete **2 only** for **US CITIZENS.**

1. Primary series of **2** or more doses of either **DPT, DT**, or **Td** vaccine at intervals not less than 0, 1, & 7 months (**Please note**—Tetanus toxoid (without Diphtheria toxoid) is **not** acceptable per State of Illinois law!) — Date of dose #1. _____ Date of dose #2. _____ Date of dose #3. _____
2. Booster dose of **Td** within **10** years of registration **(required for ALL students)** — Date of last dose: _____

TUBERCULOSIS SCREENING: **(TB Skin Test [if needed] must be done in USA and within SIX MONTHS of Registration!)**

1. Does the student have **signs or symptoms** of active tuberculosis disease? ☐ No ☐ Yes
If No, proceed to 2 If Yes, proceed with evaluation to exclude Active TB disease including TB skin test, chest x-ray and sputum evaluation as indicated
2. Is the student a **member of a high-risk group** (see list below[1]) or entering the **health professions**? ☐ No ☐ Yes
If No, Stop If Yes, place tuberculin skin test (Mantoux only) A history of **BCG** vaccination does not preclude testing of a member of a high-risk group according to US Centers for Disease Control guidelines.
3. **Tuberculin Skin Test:** **(TB Skin Test [if needed] must be done in the USA** and read **48-72 hours** after placed)
Both dates **must** include **month, day, and year** to be valid. result **must** be recorded in **millimeters** of induration, transverse diameter If no induration, write "0" — Date placed: _____ Date read. _____ Result: _____ mm induration
4. If the student has a history of **Positive TB Skin Test or treated TB Disease,** a chest X-ray done in the USA within 6 months of registration is required **Please attach chest X-ray report.** — Date of Pos PPD or TB disease. _____ Date of x-ray. _____
- Was at least 6 months of INH therapy or equivalent chemoprophylaxis completed? ☐No ☐Yes When? _____
- If student has been treated for **TB Disease:** Date diagnosed _____ Treated ___ months with _____

[1] **Categories of high-risk students** include those that have arrived within the **past 5 years** from countries where TB is endemic It is easier to identify countries of LOW rather than high prevalence Therefore students should undergo TB Skin Testing if they have **arrived in the past FIVE years from countries NOT on the following list**: American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, St Kitts and Nevis, St Lucia, San Marino, Sweden, Switzerland, United Kingdom, USA, Virgin Islands (USA) **Students from countries listed DO NOT require TB Skin Testing UNLESS** they fall under **other categories of high-risk conditions** which include those with HIV infection, who inject drugs, who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters, and **those who have clinical conditions** such as Diabetes, Silicosis, Chronic Renal Failure, Leukemias or Lymphomas, malignancies of the head, neck or lung, low body weight (10% or more below ideal), gastrectomy or jejunoileal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone 15mg/d for 1 month), pulmonary fibrotic lesions on chest x-ray, or other immunosuppressive disorders **Close contacts** of persons with Active TB and certain medically underserved populations are also considered high-risk groups who should receive the Tuberculin Skin Test.

THE FOLLOWING ITEMS ARE **REQUIRED** FOR MEDICAL, PHYSICAL THERAPY, COMMUNICATION SCIENCES & DISORDERS, SPEECH & LANGUAGE PATHOLOGY AND ALL OTHER HEALTH PROFESSIONS STUDENTS. (Highly recommended for all others):

VARICELLA (CHICKEN POX): One of the following is required.

1. 2 doses of **live** attenuated virus given at least **28** days apart — Date of dose #1. _____ Date of dose #2. _____
or 2. Confirmation by physician's records of disease history and date of conclusive diagnosis — Date of illness. _____
or 3. Positive varicella serology **(Must attach a copy of laboratory report in English.)**

HEPATITIS B: **Serology results required.** Include Dates of Vaccine if available, but Dates ALONE will NOT satisfy this requirement.

Positive serology for Hepatitis B surface antibody (10 IU/L or greater) done at least 4 weeks after third (or fourth) dose of vaccine **(Must attach a copy of laboratory report in English.)** — Date of dose #1. _____ Date of dose #2. _____ Date of dose #3. _____

THE FOLLOWING ITEM IS RECOMMENDED FOR ALL STUDENTS (Especially those in residing in University Housing):

MENINGOCOCCAL :

1 dose of meningococcal vaccine within **3** years of registration. — Date of dose. _____

Please SIGN other side of form

Exemptions from Vaccine requirements may be made for the following circumstances:

- **Medical Contraindications:** a written, signed and dated statement from a healthcare provider stating the vaccine(s) that is(are) contraindicated, the medical condition or circumstances that contraindicates such immunization(s), and duration of the medical condition that prevents administering the vaccine(s) This statement will not be accepted if it does not meet the standards of care at Northwestern University
- **Religious Exemption:** a written, signed, and dated statement from the church, student or the student's parent or guardian, if the student is a minor, documenting their objection based upon religious tenets or practice of a recognized church or religious organization, of which the student is an adherent or member Please request and complete the "Religious Waiver and Release" form
- **Pregnancy or Suspected Pregnancy:** a signed statement from a physician stating that the student is pregnant or is suspected of being pregnant Pregnancy exemptions are only applicable to Measles, Mumps, Rubella, and Varicella requirements
- **Age Exemption:** persons born before January 1, 1957 are considered immune from Measles, Mumps and Rubella

Anyone with a Vaccination Exemption may be excluded from the University campus(es) in the event of a Measles, Mumps, Rubella, Diphtheria, or Varicella outbreak in accordance with Public Health Regulations.

>>>>>RECORD REQUIRED NAME AND SIGNATURE HERE OF HEALTHCARE PROVIDER VERIFYING THE ABOVE INFORMATION<<<<<

PRINT PROVIDER'S NAME:	ADDRESS & TELEPHONE # STAMP:
SIGNATURE & DATE:	

PART V—PERMISSION FOR TREATMENT BY NORTHWESTERN UNIVERSITY HEALTH SERVICE

All students are advised to always carry their NU identification cards and the name, address, and policy number of their medical insurance. Students under the age of 18 are reminded to obtain and keep in their possession a permission-for-treatment letter signed by a parent or legal guardian in case of emergencies. Northwestern University reserves the right to have any student admitted to the University examined by a Health Service physician.

Please complete **one** of the two sections below that is appropriate for your age

PERMISSION FOR TREATMENT OF PERSONS AGE 18 YEARS AND OVER

If you are 18 years of age or older and have completed the medical history sections, Parts I & II, then you must sign this section of the form

No treatment will be provided if a signed permission for treatment form is not on file at the Health Service

I certify that the foregoing information is true and complete to the best of my knowledge I realize that the information that I have given in the medical history section is confidential and for the use of the Health Service staff. I give permission to Northwestern University to furnish such diagnostic, therapeutic, voluntary immunization, and operative procedures and transportation as may be deemed necessary on my behalf I am 18 years of age or older I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment or examination by the Health Service staff

Student's Signature **Date**

PERMISSION FOR TREATMENT OF PERSONS UNDER AGE 18 YEARS (MINORS)

If your son/daughter is a minor (under 18 years of age), you as a parent or legal guardian must sign this consent form so that the Health Service may promptly carry out appropriate diagnosis and treatment and provide emergency health service procedures with no unnecessary delay Without a signed permission for treatment, the Health Service will not treat your minor son/daughter unless an emergency exists or his/her presenting condition is exempted from requiring parental consent and/or notification by State of Illinois law Even with a signed permission for treatment, the Health Service will contact and fully inform you as parent or legal guardian before performing any major diagnostic/treatment procedure except in an emergency It should be understood that under certain circumstances your son/daughter will be transported to area hospitals for diagnosis and treatment

I certify that the foregoing information is true and complete to the best of my knowledge I realize that the information that has been given in the medical history section is confidential and for the use of the Health Service staff I give my permission to Northwestern University to furnish such diagnostic, therapeutic, voluntary immunization, and operative procedures and transportation as may be deemed necessary for my son/daughter who is under the age of 18 years I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment or examination by the Health Service staff

Student's Signature **Date**

Signature of parent/guardian **Relationship**

DO NOT WRITE BELOW THIS LINE—FOR HEALTH SERVICE USE ONLY!

RECORD REVIEW OF COMPLIANCE WITH ENTRANCE REQUIREMENTS IN THIS SECTION

☐ COMPLETE!!	☐ INCOMPLETE!!	☐ HEALTH HISTORY	☐ PPD	**Notification sent for:** ☐ DISABILITY
Date form reviewed:		☐ PERMISSION	☐ PPD VISIT	Date blue card sent:
By whom (initials):		☐ MEASLES	☐ CHEST X-RAY	By whom:
Date completed:		☐ MUMPS	☐ +PPD MD VISIT	
By whom (initials):		☐ RUBELLA	☐ VARICELLA	Date received: (Stamp here)
LATE FEE: (Stamp here)		☐ Td SERIES	☐ HEP B TITER	
		☐ Td BOOSTER	☐ OTHER _____	
		☐ PROVIDER SIGNATURE		