Immunizations Required	**Resident Student**	**Dates of Administration**
Tetanus/Diphtheria/Pertussis, **3 doses required and last dose cannot be more than 10 yrs. old**	**Required**	
Measles (2 doses) **OR** immunity by lab titre result **Diagnosis of disease is not acceptable, lab titre documentation required**	**Required**	
Mumps (1 dose) **OR** immunity by lab titre result **Diagnosis of disease is not acceptable, lab titre documentation required**	**Required**	
Rubella (1 dose) **OR** immunity by lab titre result **Diagnosis of disease is not acceptable, lab titre documentation required**	**Required**	
OR	**OR**	
MMR (2 doses) of Measles, Mumps and Rubella	**Required**	
Meningitis/one given over the age of 16	**Required**	

Health Care Provider Signature

______________________________ **Telephone Number**

______________________________ **Date**

Upon arrival at the University of St. Francis in Joliet, IL a physical exam will be performed by one of our Nurse Practitioners and a tuberculin skin test will be given by the staff at our Wellness Center.

IMMUNIZATION HISTORY

Name______________________________________ **Date of Birth**______________________________________

PLEASE READ CAREFULLY: Illinois law requires incoming students born on or after January 1, 1957 to document proof of immunity to measles, rubella, mumps and tetanus/diphtheria. This may be done by one of the following methods:

1) Attach a copy of the student's Certificate of Child Health Examination (obtain from high school health records).
2) Provide comparable documentation from prior college or university.
3) Provide verification of immunizations taken from the doctor's (MD or DO) records or other health care provider.

IMMUNIZATION: Please provide the month, day, and year for dose administered. The day and month is required if you cannot determine if the vaccine was given prior to the minimum interval or age.

	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
TETANUS/DIPHTHERIA) (within last 10 years)					
DIPHTHERIA/TETANUS/PERTUSIS, **if International Student, 3 doses required***					
MEASLES (2 doses) **OR** immunity by lab titre **OR** confirmed diagnosis					
MUMPS (1 dose) **OR** immunity by lab titre **OR** confirmed diagnosis					
Rubella (1 dose) **OR** immunity by lab titre. **Diagnosis of disease is not acceptable.**					
OR					
MMR (2 doses) of Measles, Mumps and Rubella					
TB skin test (Mantoux)	Date 1st test	Result mm	Date 2nd test	Result mm	Chest x-ray date Result
Varicella/Chickenpox (2 doses) or immunity by lab titre. **Diagnosis of disease is not acceptable.**					
Hepatitis B (3 doses)					

Please return all completed forms to Health Services, Room 232 Motherhouse or return in enclosed envelope.

STUDENT PROFILE

Please check all that apply:

_____**College of Nursing/Allied Health** ______**Resident** ________ **Commuter**

Name______ ____ SSN# _________________________
Last First M.I. (Maiden)

Date of Birth __________________

Place of Birth: State/City _____________________________

Student Address _______________________________________ Home Telephone _______________

_______________________________________ Work Telephone _______________

Parent/Spouse Name _____________________________________ Relationship ____________________

Address ____
(Street) (City) (State) (Zip)

Employer _______________________________________ Tel __________________________

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name__________________________________ Name____

Relationship____________________________ Relationship ___________________________________

Address________________________________ Address _______________________________________

Telephone _____________________________ Telephone ____________________________________

Physician Name_________________________ Physician Telephone ____________________________

Physician Address ____

____

Health Insurance Carrier ____

Policy holder's name parent/spouse ____

Policy# ________________________________ Group# ________________________________

Is the policy holder above a Health Maintenance Organization (HMO)? ________Yes_______ No

Does your insurance require pre-approval before treatment? ____________Yes________No

Does your

jlSFia

HliDpm **jMR32**

500 NW

jI 60435

Name ____

1. If yes to any questions on page one, explain thoroughly including dates and treatment:
____
____
____

2. Do you have any current restrictions related to above history? _____Yes ____ No. If yes, explain: specifically: ____
____
____

3. Have you ever had to change occupations for health reasons? ____ Yes ____ No. If yes, explain:
____
____
____

4. Are you currently under a physician's care? ___Yes ___No If yes
____
____

5. What medications (prescription and non-prescription) do you currently take? Please list.
____
____
____
____

MEDICAL RELEASE - CONSENT FORM

In the event a student at the University of St. Francis needs emergency medical treatment, a hospital will not administer treatment without the expressed permission of versity is sending this form to obtain your permission to act in your behalf in the event of any medical emergency.

Please check one:

_____ I do give the University of St. Francis permission to act in my behalf with regard to providing emergency hospital or clinic

[illegible] EXAM [illegible]

***[illegible], [illegible] [illegible] .**

[illegible]

[illegible]

Name ____Date__________________________________

Height.______ Weight. ______ B/P ______ P ______ R ______

A. [illegible]

Health Record Submission