Northwestern University Health Service
Health Information Management Services Department

Northwestern
HEALTH SERVICE

STUDENT IMMUNIZATION FORM

for all Undergraduate students and Graduate students in non-healthcare academic programs

Deadline for submitting the Student Immunization Form
Students accepted after the term deadline listed below have 30 days from date of acceptance to complete this form.

Fall Entrants	Winter Entrants	Spring Entrants	Summer Entrants
July 1	December 1	March 15	May 1

Instructions – Students registered for 2 or more ON CAMPUS classes are required to provide proof of immunization using this form. Students enrolled in online programs are exempt from the immunization requirement. Please read ALL steps listed below prior to completing this form.

1. **Student Information**–The student completes Parts I, III, IV and V. Students under age 18 on arrival, must also complete Part VI with your parent/guardian. Exceptions are noted at the top of pages 3 and 4. **THE NEXT STEP LISTS TWO WAYS TO PROVIDE PROOF OF IMMUNIZATION.**
2. **Proof of Immunization** – Provide proof of immunization by submitting **ONE** of the following:
   - Part II Required Immunizations (page 2) may be completed, signed, and dated by a healthcare professional from any country.

   OR
   - Submit a copy of your immunization record from your physician, former high school or university, State immunization registry, immigration paperwork, or other official immunization record. If your immunization record/s do not provide all of the required immunizations, you will be required to complete the missing vaccination/s.
3. **No Immunization Record** – If you have no immunization records, you have the option to complete blood tests to prove immunity to Measles, Mumps and Rubella or be revaccinated. Revaccination is the only option for the Tetanus/Diphtheria/Pertussis requirement and an extension may be granted to complete the three dose series after the deadline, when necessary.
4. **NO PHYSICAL EXAM IS REQUIRED.**
5. **Submit documentation** – Submit your documentation online by going to the Health Service Evanston website at https://www.northwestern.edu/healthservice-evanston/index.html. Click on the Personal Health Portal link under ***Access Care*** and enter your net ID and password which you also use for CAESAR. You will then need to enter your 7 digit student ID from your Wildcard or CAESAR. Select "immunization Upload" from the list along the left hand side of the page to upload your documentation. If you prefer or are not able to upload your record, you may MAIL to: Northwestern University Health Service, Health Information Management Service, 633 Emerson Street, Evanston, IL 60208 or FAX to: 847-491-8699.
6. **Confirmation –** Your Northwestern email address will be used to communicate completion of immunization requirements or any immunization deficiencies.
7. **Penalties** – Students who fail to submit the completed *Student Immunization Form*, including proof of immunizations and fail to rectify deficiencies **within 30 days after the start of classes** will be:
   - Assessed a non-refundable $100 late fee
   - Barred from class registration for subsequent terms until compliant in accordance with Illinois law
8. **Questions** – For detailed information, visit the New Students tab on the Evanston campus Health Service website: https://www.northwestern.edu/healthservice-evanston/index.html

PART I: STUDENT AND ACADEMIC INFORMATION

_____ _____ _____ _____
Last name First name Middle Preferred name

_____
Permanent Address

_____ _____ Sex at birth: ___ Female ___Male
Date of Birth (mm/dd/yyyy) Student ID (7 digit number)

First Term attending and year of enrollment: Fall 20____ Winter 20____ Spring 20____ Summer 20____

I will be registered for: ____ 2 credits ____ 3 or more credits

I am an exchange student and will be enrolled for: _____ One term _____ Two or more terms

Indicate your academic program: ____Undergraduate ____Graduate ____ Kellogg Executive MBA

Northwestern University
PART II: REQUIRED IMMUNIZATIONS

Students registered for two or more classes are required by Northwestern and Illinois law to submit proof of immunization. **THIS PAGE MUST BE COMPLETED BY A HEALTHCARE PROVIDER from any country (e.g. doctor or nurse),** and include their printed name, signature and date at the bottom, to be considered valid under Illinois State Law. Vaccination dates should be listed in month/day/year format.

Instead of having this page completed by your doctor, you may submit a copy of an immunization record/s from your doctor, former high school or university, State immunization registry, immigration paperwork, or other official immunization record which provides all of the required vaccinations listed below. All records must be submitted in English.

Student Name: _____ **Student ID:** _____ **Date of Birth:** _____

Students born prior to 1/1/1957 are NOT required to submit immunization records - enclose a copy of your driver's license instead of this page.

M-M-R (COMBINED Measles, Mumps, Rubella) vaccination (**2** doses required).

- **If given individually, complete section below instead.**

Dose #1 (on or after 1st birthday **AND** after 1/1/68): ____/____/_____ (mm/dd/yyyy)

Dose #2 (at least 28 days after dose #1): ____/____/_____ (mm/dd/yyyy)

MEASLES (Rubeola)	MUMPS	RUBELLA (German Measles)
2 doses required. Both must be done on or after 1st birthday, after 1/1/68, and at least 28 days apart.	**2 doses** required. Both must be done on or after 1st birthday, and at least 28 days apart.	**2 doses** required. Both must be done on or after 1st birthday, and at least 28 days apart.
Dose #1: ____/____/_____	**Dose #1:** ____/____/_____	**Dose #1:** ____/____/_____
Dose #2: ____/____/_____	**Dose #2:** ____/____/_____	**Dose #2:** ____/____/_____
OR - **Attach copy of lab report** (titer) confirming immunity (antibodies).	**OR** - **Attach copy of lab report** (titer) confirming immunity (antibodies).	**OR** - **Attach copy of lab report** (titer) confirming immunity (antibodies).

TETANUS/DIPHTHERIA/PERTUSSIS - 3 doses of DTP, DTaP, Td, DT or Tdap are required; please list dates in boxes below**.**

- The first 2 doses **MUST** be at least 28 days apart.
- The 3rd dose **MUST** be completed within **10 years** prior to entrance into University and at least 6 months after last primary series vaccination.
- **One dose MUST be a Tdap**, which is a vaccination only given to adolescents and adults; it is not given to infants or children.

☐**DTP/DTaP** ☐**Td** ☐**Tdap**	☐**DTP/DTaP** ☐**Td** ☐**Tdap**	☐**DTP/DTaP** ☐**Td** ☐**Tdap**
Dose #1: ____/____/_____	**Dose #2:** ____/____/_____	**Dose #3:** ____/____/_____

MENINGOCOCCAL CONJUGATE (Undergraduate students only)

- Required for students age 21 years or younger at the start of classes.
- MUST have been completed at 16 years of age or older.

Date: ____/____/_____

RECOMMENDED (NOT REQUIRED):
VARICELLA (Chicken pox) - Dose #1: ___/____/_____ Dose #2: ___/____/_____ Date of Illness: ___/____/_____
HEPATITIS B - Dose #1: ___/____/_____ Dose #2: ___/____/_____ Dose #3: ___/____/_____
HPV (Human Papillomavirus) - Dose #1: ___/____/_____ Dose #2: ___/____/_____ Dose #3: ___/____/_____

Healthcare Provider: By signing below, you attest that all information supplied in this section is true and correct to the best of your knowledge.

Name and title of Provider (printed): _____

Signature of Provider: _____ **Date:** ____/____/_____

Phone Number: (_____)_____

Address

Exemptions: If you feel that you are exempt from vaccination requirements based on a medical contraindication, religious belief, or pregnancy, contact Health Information Management Services at the Northwestern Health Service at 847-491-2203 to discuss the required procedure and documentation.

PART III: TUBERCULOSIS SELF-SCREENING (completed by student)

EXCEPTION: NOT REQUIRED FOR STUDENTS REGISTERED FOR ONLY TWO CLASSES AND KELLOGG EXECUTIVE MBA STUDENTS.

Student Name: _____ Student ID: _____Date of Birth: _____

Begin with the 1st question and circle the appropriate response. If you answer "NO", proceed to the next question until all questions are answered. If you answer "YES" to any question, proceed to Instruction Set A or B as directed. Once you answer "YES" to a question, do not answer the remaining questions.

1. Do you currently have any of the following unexplained or undiagnosed symptoms: Fever, weight loss, swollen lymph nodes, night sweats, cough for greater than 1 month? **If "YES", contact your healthcare provider immediately. Follow Instruction Set "A" below.**	**YES**	**NO**
2. Have you ever been diagnosed with tuberculosis? **IF "YES", follow Instruction Set "B" below.**	**YES**	**NO**
3. Have you ever had a positive skin test (PPD) or positive TB blood test? **IF "YES", follow Instruction Set "B" below.**	**YES**	**NO**
4. **In the last 5 years,** have you lived or traveled in a country **NOT** listed below, for a period **longer than 1 month**? **IF "YES", follow Instruction Set "A" below.**	**YES**	**NO**

Albania, American Samoa, Andorra, Antigua & Barbuda, Aruba, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Lebanon, Luxembourg, Macedonia, Malta, Monaco, Montserrat, Montenegro, Netherlands, New Caledonia, New Zealand, Norway, Oman, Puerto Rico, St. Kitts & Nevis, St. Lucia, Slovakia, Slovenia, Samoa, San Marino, Saudi Arabia, Spain, Sweden, Switzerland, Syrian Arab Republic, Tokelau, Tonga, United Arab Emirates, United Kingdom, United States, US Virgin Islands, West Bank & Gaza.

5. Do you currently have one or more of the following medical conditions listed below? **IF "YES", follow Instruction Set "A" below.**			**YES** **NO**
Diabetes Silicosis Chronic kidney failure Leukemia or lymphoma IV Drug Use Organ transplant	Low body weight (10% or more below ideal) Gastrectomy Jejunoileal (intestinal) bypass Cancer of the head, neck, or lung	Chronic malabsorption syndromes (i.e. Crohn's or ulcerative colitis) Pulmonary fibrotic lesions on chest x-ray	Abnormal immune system (including HIV/AIDS, cancer chemotherapy, etc.) Prolonged corticosteroid therapy (e.g. Prednisone 15mg/daily or more for 1 month) or other immunosuppressive treatment

6. In the last 5 years, have you worked, lived or volunteered in a hospital or other healthcare facility, homeless shelter, prison, nursing home, or HIV/AIDS clinic in a capacity where you had contact with patients and/or residents? **IF "YES", follow Instruction Set "A" below.**	**YES**	**NO**
7. Have you had close contact with someone with active tuberculosis OR a medically underserved population which is at high-risk for tuberculosis? **IF "YES", follow Instruction Set "A" below.**	**YES**	**NO**

IF YOU ANSWERED "NO" TO ALL OF THE QUESTIONS ABOVE, YOUR TUBERCULOSIS REQUIREMENT IS COMPLETE.

STUDENTS ARRIVING FROM OTHER COUNTRIES who need to complete a TB test or Chest X-Ray, will use the Evanston or Chicago Health Service to complete this requirement; the cost is covered by the NU-SHIP. When your Student Immunization Form is processed, an email will be sent to your Northwestern email with instructions on how to schedule an appointment after your arrival.

INSTRUCTION SET A: You are required to submit proof of a TB test that was performed **within 6 months** prior to entrance into Northwestern. Acceptable TB tests include:

- **Interferon-Gamma Release Assay (IGRA):** Includes QuantiFERON® TB Gold or T-SPOT blood tests. May be completed in any country and a copy of the lab report must be attached. Lab reports from outside the USA must be in English.
- **TB skin test (PPD):** Healthcare provider must supply date placed, date read and result in mm induration. **Must be completed in the USA.**

PLEASE NOTE: If PPD result is >= 10mm or the TB blood test is positive; you are also required to follow **INSTRUCTION SET B** below.

INSTRUCTION SET B: You are required to **1)** submit a report from a Chest X-Ray performed **in the USA within 6 months** prior to entrance into Northwestern **OR** negative Interferon-Gamma Release Assay (IGRA) performed **within 6 months** prior to entrance into Northwestern, **and 2) if treated for tuberculosis,** a copy of any treatment, including medications and dates of treatment with this form. Upon arrival to campus, you may also be required to meet with a Health Service physician to review these documents.

PART IV: HEALTH HISTORY

Student Name: _____ **Student ID:** _____ **Date of Birth:** _____

EXCEPTION: Completion of the health history is only required for students who plan to use the Evanston Health Service for their healthcare needs. All other students may skip this health history section and proceed to the signature section below.

PLEASE CHECK YES OR NO (Y/N), PROVIDING SPECIFIC DETAILS TO ALL" YES" ITEMS TO THE BEST OF YOUR KNOWLEDGE.

Y	N	ITEM	DETAILS (list specific information)
		Allergies (any)	
		Will you be receiving allergy shots at the Evanston Health Service?	If you answer "Yes", please refer to the following link to print additional required forms: http://www.northwestern.edu/healthservice-evanston/medical-services/allergy-shots/index.html
		Adverse Medication Reaction	
		Current medications (prescription or other) If so, list frequency and length of time taken.	

ITEM	Y	N	YEAR	Check each item:	Y	N	YEAR
Alcohol or drug problems				Epilepsy/Seizure Disorder			
Appendectomy				Fractures/Broken Bones			
Asthma				Heart condition, disease, or murmur			
Attention Deficit/Hyperactivity Disorder				HIV test Positive or AIDS			
Cancer, leukemia, or lymphoma				High Blood Pressure			
Chicken Pox/Varicella				Migraine Headaches			
Cholesterol or lipid problems				Mononucleosis/Epstein-Barr Virus			
Concussion/Mild Traumatic Brain Injury				Sexually Transmitted Diseases			
Depression or Anxiety (specify)				Splenectomy			
Diabetes Mellitus				Tonsillectomy			
Eating Disorder/Anorexia/Bulimia				Transfusion of blood/blood product			
Emotional/Psychological problems				Viral Hepatitis (specify, e.g. A, B, C)			

Other surgical/medical condition not listed: _____

_____

PART V: STUDENT SIGNATURE (REQUIRED)

Please sign and date below. By signing you are certifying that all information supplied is correct to the best of your knowledge.

_____

Signature Date

PART VI: TREATMENT/SHARING OF MEDICAL INFORMATION OF MINORS (UNDER AGE 18 YEARS)

As the parent/guardian of my minor (under 18 years of age) son or daughter, I hereby authorize:

1) The sharing/exchange of relevant medical information between Northwestern University representatives (officials, faculty, staff), Northwestern University Health Service, and, for the purpose of diagnosis and/or treatment, other medical providers. Each of the above individuals or entities is also authorized to communicate and discuss health matters with the parents/guardians/emergency contacts of my minor child.
2) The transportation of my minor child, under appropriate circumstances, to area hospitals for diagnosis and treatment.
3) The provision, by the Northwestern University Health Service, of such diagnostic, therapeutic, voluntary immunization, and operative procedures as may be deemed necessary for my minor child.

Any and all related expenses will be the responsibility of the student and/or parent/guardian.

Student's Signature: _____ Date: _____

Signature of parent/guardian:_____ Relationship: _____ Date: _____