



STUDENT INFORMATION (this section must be completed):

Last Name	First Name and Middle Initial	Date of Birth (mm/dd/yyyy)	DePaul Student #
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I authorize DePaul University to release this immunization record to the Illinois Department of Public Health, or its designated representative for compliance audits or in the event of a health emergency. All immunization documents submitted to DePaul become the property of the University. I understand that, unless required to do so by law, DePaul University will not re-release my immunization documentation to me or any other academic institution or third party.

Student Signature : _____ Date: _____

Please complete either Option A or Option B

- Option A: Include a copy of your Official Immunization Records proving ALL immunizations. (SKIP OPTION B)
- Option B: See below – Remainder of form to be completed and signed by physician or health care provider.

OPTION B: To be completed and signed by physician or health care provider. Please note the following:

- **Positive** laboratory (serologic) evidence of immunity via blood (antibody) titer is acceptable proof for Measles, Mumps and Rubella.
- Anyone with a vaccine exemption may be excluded from the college/university in the event of an outbreak in accordance with public health recommendations.
- **All documents must be in English** or accompanied by a certified translation.

<p>*TETANUS/ DIPHTHERIA/ PERTUSSIS– THREE (3) doses of DTP, DT, Td or Tdap are required. One of the three doses must be Tdap. Last dose must be received within the past 10 years.</p> <p>*Blood Titer is not accepted for Tetanus/ Diphtheria / Pertussis</p>	<p>Dose 1</p> <p>Td <input type="checkbox"/> DTap <input type="checkbox"/> Tdap <input type="checkbox"/></p> <p>____/____/____ MM DD YYYY</p>			<p>Dose 2</p> <p>Td <input type="checkbox"/> DTap <input type="checkbox"/> Tdap <input type="checkbox"/></p> <p>____/____/____ MM DD YYYY</p>			<p>Dose 3</p> <p>Td <input type="checkbox"/> DTap <input type="checkbox"/> Tdap <input type="checkbox"/></p> <p>____/____/____ MM DD YYYY</p>		
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<p>MEASLES/ MUMPS/ RUBELLA – TWO (2) doses of MMR are required. Both doses must be taken on or after 1st birthday and at least 28 days apart. Neither dose can be prior to 1968.</p>	<p>MMR Dose 1</p> <p>____/____/____ MM DD YYYY</p>	<p>Measles Dose 1</p> <p>____/____/____ MM DD YYYY</p>	<p>Mumps Dose 1</p> <p>____/____/____ MM DD YYYY</p>	<p>Rubella Dose 1</p> <p>____/____/____ MM DD YYYY</p>
	<p>MMR Dose 2</p> <p>____/____/____ MM DD YYYY</p>	<p>Measles Dose 2</p> <p>____/____/____ MM DD YYYY</p>	<p>Mumps Dose 2</p> <p>____/____/____ MM DD YYYY</p>	<p>Rubella Dose 2</p> <p>____/____/____ MM DD YYYY</p>
	<p><input type="checkbox"/> OR positive blood titer with REQUIRED copy of lab report.</p>			

<p>*MENINGOCOCCAL CONJUGATE– ONE (1) dose required if under 22 years old, taken on or after 16th birthday.</p> <p>*Meningitis B is not acceptable</p>	<p>Dose 1</p> <p>____/____/____ MM DD YYYY</p>			
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<p>COVID-19 VACCINATION– TWO (2) doses. Both must be from the same manufacturer. Or ONE (1) dose from Johnson & Johnson.</p> <p>Pfizer: 3 weeks (21 days) apart Moderna: 4 weeks (28 days) apart</p>	<p>Dose 1</p> <p>____/____/____ MM DD YYYY</p>	<p>Manufacturer (Johnson & Johnson/ Pfizer/ Moderna /Other)</p> <p>_____</p>	<p>Dose 2</p> <p>____/____/____ MM DD YYYY</p>	<p>Manufacturer (Johnson & Johnson/ Pfizer/ Moderna /Other)</p> <p>_____</p>
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Physician or public health official verification - I verify to the best of my knowledge that the above immunization information is correct.

Physician Name (print or stamp)	Physician's Phone #:
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Physician's Signature:	Date (mm/dd/yyyy)
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This form must be completed and returned with applicable attachments before the student is allowed to register.

To submit this form and/or additional records: Scan or take a photo of this completed form and any additional documents, then login to [Campus Connect](#). For Current students: click the Student Resources Tile > Immunization Status. For Admitted students: click the Next Steps Tile > Immunization Status.

For more information visit: go.depaul.edu/immunizations.

For DePaul Central Office Use Only:	Partial:	Complete:	Hold Removed:
Date: _____	Staff Initials: _____	<input type="checkbox"/>	<input type="checkbox"/>