ROOSEVELT UNIVERSITY
COLLEGE OF SCIENCE, HEALTH AND PHARMACY

IMMUNIZATION RECORDS

Illinois Public Health Act 85-1315 requires that records be on file at Roosevelt University for all students (1) born on or after January 1, 1957 **AND** (2) enrolled for six or more credit hours per semester. The records need to be on file for reports to the State within the first term of enrollment.

Please submit your immunization records per the instructions below. If you cannot secure a copy of your records from your high school or a previously-attended college, you should see your physician as soon as possible to secure a copy, arrange to have the immunizations, or get the blood titer to show proof of immunization.

IMMUNIZATION RECORDS MUST BE ON FILE BEFORE A STUDENT CAN ATTEND CLASSES.

General Instructions and Information

1. All required vaccines are based on the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommendations for health-care professionals. Please refer to these recommendations for further detail.
2. Complete the Immunization History, attach all necessary documents that show evidence of immunization and submit to Claudia Muldoon, Experiential Education Advisor. Completed forms can be emailed to Claudia Muldoon, cmuldoon@roosevelt.edu or mailed to Roosevelt University CSHP 1400 N. Roosevelt Blvd. Schaumburg, Illinois 60173 Attn: Claudia Muldoon. **All information submitted must be in English.**
2. High school or college immunization records are acceptable, provided they are properly certified and contain all information on the required immunizations.
3. If you are on an approved schedule to receive all necessary doses of a vaccine, you must include the date of the first dose and expected dates of the remaining doses.
4. Please include the month, day, and year of all information, wherever possible.
5. A physician, institutional Health Service Registered Nurse or public health official must certify all dates by signature and include his or her address and phone number for verification.
6. Any laboratory or radiologic evidence you submit must include your name, test date(s) and results.

If you have any questions about the procedures described above, please call the Office of Enrollment and Student Services at 847-330-4500, Monday through Friday, 9:00am to 5:00pm Central Standard Time. If you leave a message, please provide detailed information, including your name and telephone number.

NOTE: IMMUNIZATION RECORDS ARE KEPT ON FILE FOR 10 YEARS FROM THE FIRST SEMESTER OF ATTENDANCE.

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All information submitted must be in English. A physician, institutional Health Service Registered Nurse or public health official must certify all dates by signature and include his or her address and phone number for verification.

COMPLETED IMMUNIZATION RECORDS MUST BE ON FILE BY June 01, 2025 OR THE STUDENT WILL NOT BE ALLOWED TO ATTEND CLASSES.

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Immunization Requirements **FOR ALL STUDENTS**

Type of Immunization	Records Should Show	If No Records Are Available
MEASLES (RUBEOLA) **MUMPS** **GERMAN MEASLES (RUBELLA)**	Two doses MMR vaccine given after the 1st birthday and at least one month apart This is required, regardless of date of birth.	Titer test must be done to show if you have been immunized. If Titer test shows negative for immunization, you must get all the required shots before attending classes.
TETANUS AND DIPTHERIA	TD or DT or TdaP required (Tetanus toxoid (TT) not acceptable). Three primary series immunizations are needed. A three dose series-commonly given in childhood.	You will need to take a booster and provide date of last booster. Booster must be within last 10 years. **OR** Exempt status conferred. There must be a physician's statement for any exempt status.
POLIO	A three dose series-commonly given in childhood.	Need to take a booster shot and provide records of it. **OR** Be immunized as an adult; please provide dates for immunization dates.
TUBERCULOSIS	**Initial Screening** Two separate PPD skin tests within a 9-10 day period of time (2-step testing) Annual screening Note: All of our hospitals use the 2 step TB. As long as the student **does not let the TB test expire** they only have to get a yearly TB test. If they do it even a day after their initial TB, they have to do a 2 step.	**Students with a history of a positive PPD skin test:** Chest x-ray done within the past 12 months in the United States **AND** Annual Provider review **OR** **Annual QuantiFERON –gold (Preferred)**
HEPATITIS B	Three immunizations are needed **AND** The documentation of immunity by Titer	Titer test must be done to show if you have been immunized. If Titer test shows negative for immunization, you must get all the required shots before attending classes.
VARICELLA ZOSTER (CHICKEN POX)	A positive blood test showing immunity is required if student has history of chicken pox. **OR** If no history of chicken pox, documentation of a two dose series.	Titer test must be done to show if you have been immunized. If Titer test shows negative for immunization, you must get all the required shots before attending classes.

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MANDATORY PHARMACY STUDENT IMMUNIZATION HISTORY

Please complete with your health care provider and return in the enclosed envelope before you arrive on campus. You may attach additional immunization information from other schools or medical offices. **Responses must be in English**.

Student Information

Name:_____ Student ID#: _____

Email:_____ Phone: _____

MEASLES (RUBEOLA)

☐ Immunity confirmed by Titer. Date of Titer _____

Results_____ Date of re-immunization: _____

Attach copy of lab report

MUMPS

☐ Immunity confirmed by Titer. Date of Titer _____

Results_____ Date of re-immunization: _____

Attach copy of lab report

GERMAN MEASLES (RUBELLA)

☐ Immunity confirmed by Titer. Date of Titer _____

Results_____ Date of re-immunization: _____

Attach copy of lab report

TETANUS AND DIPTHERIA

TD or DT or TdaP required (Tentanus toxoid (TT) not acceptable). Three primary series immunizations are needed OR date of last booster OR
exempt status conferred. Please fill in the relevant portion below.

☐ Immunization 1 – Date _____

☐ Immunization 2 – Date _____

☐ Immunization 3 – Date _____

OR

☐ Last Booster Shot – Date _____ (Booster must be within last 10 years) OR

☐ Exempt Status, Date of exemption_____(*Attach physician's statement*)

POLIO

Three immunizations are needed OR date of last booster OR date of immunization as an adult. Please fill in the relevant portion below.

☐ Immunization 1 – Date _____

☐ Immunization 2 – Date _____

☐ Immunization 3 – Date _____

OR

☐ Last Booster Shot___
☐ Oral (Sabin) ☐ Injection (Salk)
Date

OR Immunized as an Adult. Date conferred _____

TUBERCULOSIS (Check the appropriate box)

☐ HAS HAD THE DISEASE ☐ HAS NOT HAD THE DIESEASE

AND fill out the appropriate section below for annual updates: NOTE: TUBERCULIN SKIN TEST (TST) 2 STEP MAY BE REQUIRED. TST READING MUST BE DONE FROM 48 HOURS AFTER APPLICATION.

☐ TST Step 1 Date read_____ Result_____mm induration

☐ TST Step 2 Date read_____ Result_____mm induration

OR

☐ Had a positive Mantoux skin test. Year of skin test _____Attach documentation results and copy of chest x-ray report.

Baseline Chest X-Ray Date _____ ☐ Positive ☐ Negative

☐ Had BCG vaccine. Date _____

OPTIONAL

☐QTBG Quantiferon-Gold Blood Test

Date: _____

Result: _____

HEPATITIS B Three immunizations are needed AND the documentation of immunity by titer. Please fill in the relevant portion below.

☐ Immunization 1 Date _____

☐ Immunization 2 Date _____

☐ Immunization 3 – Date _____

AND

☐ Immunity confirmed by Titer. Date of Titer _____

HB surface antigen ☐ Positive ☐ Negative

HB surface antibody ☐ Positive ☐ Negative

Antibody must be positive. If the antibody titer is negative, the antigen is required. Repeat immunization may be required under certain circumstances. *Attach copy of lab report*.

VARICELLA ZOSTER (CHICKEN POX)

☐ Immunity confirmed by Titer. Date of Titer _____

Results_____ Date of re-immunization: _____

Attach copy of lab report

CERTIFICATION BY HEALTH CARE PROFESSIONAL

Name_____(circle one) RN MD DO RPH

Name and address of institution or clinic (or stamp)

Phone_____ FAX _____

I certify that this information is complete and correct to the best of my knowledge.

Signature of Health Care Provider Date