

IMMUNIZATION COMPLIANCE FORM

Please complete the **STUDENT INFORMATION** section and attach immunization records; OR have a health care provider complete this form. Submit on-line at shc.siu.edu using the Saluki Health Portal; e-mail to immunizations@siu.edu; fax 618/453-4452 or mail to SIU Student Health Services, Immunization Compliance, MC6740, 374 East Grand Ave., Carbondale, IL 62901. Immunization Phone Number: 618/453-4326

STUDENT INFORMATION

First Name: _____ Last Name: _____ MI: _____ Date of Birth: _____ (mm/dd/yy):
 Age: _____ Gender: _____ Dawg Tag #: _____ Term (Semester/Year) Entering SIU: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Preferred method of contact: Phone: _____ Text: _____ Email: _____

INTERNATIONAL STUDENTS:

Tuberculosis screening will be performed at Student Health Center when you arrive on the SIU Carbondale campus. Please bring a copy of this form and any related immunization documents. All documents must be in English; if not, provide a certified translation. Please call 618/453-4326 to schedule your Tuberculosis screening.

PLEASE LIST YOUR COUNTRY OF ORIGIN:

REQUIRED IMMUNIZATIONS

MEASLES-MUMPS-RUBELLA - 2 doses against MMR (EXEMPT: if born on or before 1/1/57 with documents)

OR	MMR 2 doses of Measles, Mumps, and Rubella. All doses must be on or after 1st birthday, at least 28 days apart, both after 12/31/67. mm/dd/yy mm/dd/yy Positive serum titers are also acceptable proof of immunity for measles, mumps, and rubella. Copies of reports MUST be attached. <input type="checkbox"/> Required lab report attached Documentation of dates of disease IS NOT acceptable evidence of immunity against measles, mumps or rubella.	MEASLES (Rubeola; Hard, Red, or Seven Day) 2 doses of Measles. All doses must be on or after 1st birthday, at least 28 days apart, both after 12/31/67. 1 2 mm/dd/yy mm/dd/yy
	MUMPS 2 doses of Mumps. All doses must be on or after 1st birthday and at least 28 days apart. 1 2 mm/dd/yy mm/dd/yy	
	RUBELLA (German or 3 day Measles) 2 doses of Rubella. All doses must be on or after 1st birthday and at least 28 days apart. 1 2 mm/dd/yy mm/dd/yy	

TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DTaP, Tdap) **ALL STUDENTS** must show proof of **3** Tetanus vaccinations containing Pertussis. One **MUST** be a Tdap. One Td or Tdap **MUST** be within the last 10 years. Tetanus toxoid (TT) is not acceptable.

1 <input type="checkbox"/> DTP <input type="checkbox"/> DTaP <input type="checkbox"/> DPT <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> Adacel <input type="checkbox"/> Boostrix mm/dd/yy	2 <input type="checkbox"/> DTP <input type="checkbox"/> DTaP <input type="checkbox"/> DPT <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> Adacel <input type="checkbox"/> Boostrix mm/dd/yy	3 <input type="checkbox"/> DTP <input type="checkbox"/> DTaP <input type="checkbox"/> DPT <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> Adacel <input type="checkbox"/> Boostrix mm/dd/yy
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MENINGITIS: The Meningococcal Conjugate Vaccine is **REQUIRED** for all incoming students under the age of 22. If the vaccine was received prior to age 16, a booster is required.

1 mm/dd/yy	2 mm/dd/yy	<input type="checkbox"/> Menactra <input type="checkbox"/> Menveo <input type="checkbox"/> Meningococcal Conjugate
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RECOMMENDED IMMUNIZATIONS

<input type="checkbox"/> COVID-19	1 <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> J&J Janssen mm/dd/yy	2 <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer mm/dd/yy	Booster <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> J&J Janssen mm/dd/yy
<input type="checkbox"/> HEPATITIS A	1 mm/dd/yy	2 mm/dd/yy	
<input type="checkbox"/> HEPATITIS B	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
<input type="checkbox"/> HPV (Gardasil 9) <input type="checkbox"/> HPV (Gardasil) <input type="checkbox"/> HPV (Cervarix)	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
<input type="checkbox"/> VARICELLA	<input type="checkbox"/> Lab test proving immunity (attach lab report)	1 mm/dd/yy	2 mm/dd/yy
<input type="checkbox"/> SEROGROUP B MENINGOCOCCAL	MenB-RC (Bexsero) 2 doses of Bexsero.	1 mm/dd/yy	2 mm/dd/yy
	OR MenB-FHbp (Trumenba) 3 doses of Trumenba.	1 mm/dd/yy	2 mm/dd/yy 3 mm/dd/yy

HEALTH CARE PROVIDER (MD, DO, APN, NP, PA, RN, LPN, MA, Pharm.D., R.Ph.) **VERIFY THAT IMMUNIZATIONS WERE GIVEN.**

Provider Name (please print)	Signature/Credentials
Address	Date
City, State, Zip	Phone