Illinois Department of Health

CERTIFICATE OF IMMUNITY

(Part I - To be Completed by Student)

_____

Last name (please print) First Middle Initial Student ID#

Date of birth _____/_____/_____ Sex: ___M ___F Home Telephone # ( ) _____ – _____

Semester ____ Fall ____ Spring Year_____

(Part II - Attach a Copy of Certificate of Child Health Examination)

If you can provide a copy of a certificate of health examination as required proof of immunity to the childhood diseases listed below then DO NOT FILL OUT PART III.

I authorize **Columbia College Chicago** to release this immunization record to the Illinois Department of Public Health, or its designated representative for compliance audits and in the event of a health or safety emergency.

Student's Signature_____ Date_____

(Part III - To be completed and signed by health care provider* All Dates Must Include MO/DAY/YR)

Measles (Rubeola)

✓ YES

1) Disease confirmed by physician's records? ❍ Date of illness ___/____/___
2) Immunity confirmed by blood titer? ❍ Date of test ___/____/___(Attach copy of lab report)
3) Immunization with live virus vaccine? ❍ Date of shot ___/____/___(Must include two dates)
Note: Given in 1968 or later ___/____/___
4) Exemption? ❍ Attach physician's statement of contraindication

Signature of Physician_____

Rubella (German Measles)

1) Immunity confirmed by blood titer? ❍ Date of test ___/____/___(Attach copy of lab report)
2) Immunization with live virus vaccine? ❍ Date of shot ___/____/___
3) Exemption? ❍ Attach physician's statement of contraindication

Signature of Physician_____

Mumps

1) Disease confirmed by physician's record ❍ Date of illness ___/____/____
2) Immunization with live virus vaccine? ❍ Date of shot ___/____/____
3) Exemption? ❍ Attach physician's statement of contraindication

Signature of Physician_____

Tetanus/Diphtheria

1) Primary series completed? ❍ Date ___/____/____
Note: Must include at least two dates ❍ Date ___/____/____
2) Most recent booster? (Must be within last 10 yrs) ❍ Date ___/____/____
3) Exemption? ❍ Attach physician's statement of contraindication

Signature of Physician_____

(Part IV - Verification)

Can be verified by health care provider or official designated record keeping office verifying information.

Name_____Signature_____Phone#_____

**** Note: Physician licensed to practice medicine in all of its branches (M.D. or D.O.) local health authority, college or university health service or a Department recognized vaccine provider.***