

MIDWESTERN UNIVERSITY IMMUNIZATION REQUIREMENTS
BIOMEDICAL SCIENCES

Name: _____ Sex: _____

Date of Birth: _____ Social Security Number: _____

Telephone Number: _____ (home) _____ (daytime)

I authorize Midwestern University to release this immunization record to external rotation sites &/or to the Illinois Department of Public Health for compliance audits and in the event of a health or safety emergency.

Student's Signature _____ Date _____

TO BE COMPLETED BY HEALTH CARE PROVIDER: This form, in addition to all other documentation that is submitted, must have a healthcare provider's signature and contact information.

Please read through the entire form before attempting to fill it out. A more detailed explanation is included in this packet. Please call Midwestern University Wellness Center if you have ANY QUESTIONS at (630) 515-7233. They will be more than happy to help you.

IMMUNIZATION DOCUMENTATION: Please provide official documentation of dates for the following:

MEASLES/MUMPS/RUBELLA COMBINED (MMR) DO NOT list these dates under the immunizations below.

1st Date: _____ 2nd Date: _____
(month-day-year) (month-day-year)

—OR—

MEASLES (Rubeola) Two immunizations with live virus vaccine (**the FIRST occurring at 12 months of age or older**)

1st Date: _____ 2nd Date: _____
(month-day-year) (month-day-year)

MUMPS One immunization with live virus vaccine (**the FIRST occurring at 12 months of age or older**)

If you had a second immunization please include that information below.

1st Date: _____ 2nd Date: _____
(month-day-year) (month-day-year)

GERMAN MEASLES (Rubella) One immunization with live virus vaccine (**FIRST occurring at 12 months of age or older**)

If you had a second immunization please include that information below.

1st Date: _____ 2nd Date: _____
(month-day-year) (month-day-year)

TETANUS/DIPHTHERIA

All students must have documentation of one Td received within the last 10 years. You must receive this immunization every 10 years.

Date of immunization: _____
(month-day-year)

COMPLETE THE SECTION BELOW IF YOU WERE NOT BORN IN THE UNITED STATES

If you were **NOT BORN in the United States** you must supply dates for your two **ADDITIONAL** most recent immunizations (DPT, DT, Td). Do not include the same date as given above.

2nd Date: _____ 3rd Date: _____
(month-day-year) (month-day-year)

MIDWESTERN UNIVERSITY IMMUNIZATION REQUIREMENTS

MANTOUX TUBERCULOSIS SCREENING – MUST BE A 2 STEP PPD/TB SKIN TEST

This **MUST** be a **Mantoux test** with 0.1 ml of 5TU PPD tuberculin injected **intradermally**. TB Tine tests are **NOT ACCEPTABLE**. The PPD/TB results **MUST** indicate the **date given, the date it was read 48 to 72 hours later by a health care professional**, and the **reading in millimeters**. This screening is not valid unless all of the required information is recorded. Failure to include the **DATE GIVEN, DATE READ** and **READING IN MILLIMETERS** will result in your having to repeat the screening. Any TB reading of 10mm or over is positive—see Positive TB Results section below.

THE PPD/TB TEST MUST BE A 2 STEP TEST TO SERVE AS THE BASELINE READING. THE SECOND STEP (TEST) MUST BE DONE 1-3 WEEKS AFTER THE FIRST TEST IS GIVEN. THEREAFTER, WHILE ENROLLED AS A STUDENT AT MWU, YOU WILL BE REQUIRED TO COMPLETE A NEW PPD/TB TEST EVERY 12 MONTHS. BE SURE TO HAVE THE TEST REPEATED YEARLY SO THAT YOU STAY IN COMPLIANCE.

STEP 1 TEST
Date Given: _____ Date Read: _____ Results: _____ mm (month-day-year) (month-day-year) (<u>in mm's</u>)
STEP 2 TEST – Done 1-3 weeks after the first test is given
Date Given: _____ Date Read: _____ Results: _____ mm (month-day-year) (month-day-year) (<u>in mm's</u>)

Positive TB Results– If you have a positive TB test or history of a positive TB test in the past, you must provide proof of such. In addition, you **MUST** provide a **Chest X-Ray Report** done within the last 12 months. As an enrolled student, you will need to provide a new chest x-ray report every other year. All Chest X-ray reports MUST be type written and signed by a radiologist.

Date Chest X-ray Taken: _____ (month-day-year)
Copy of Chest X-ray Results Attached: <input type="checkbox"/>

HEPATITIS B IMMUNIZATION

<p>Three doses of Hepatitis B vaccine are required - One month between 1st and 2nd doses, 5 months between the 2nd and 3rd doses. Please follow this schedule as closely as possible so that you can save yourself the time and cost of having to get a booster or even having to repeat the series if your titer comes out low or negative</p> <p>1st Date: _____ 2nd Date: _____ 3rd Date: _____ (month-day-year) (month-day-year) (month-day-year)</p>
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If you cannot provide proper documentation for the series of three Hep B shots then you must have the following titers done:

<p>1. HEPATITIS B SURFACE ANTIBODY (HepBs AB) QUANTITATIVE TITER Date Drawn: _____ Lab Report Attached: <input type="checkbox"/></p> <p>2. HEPATITIS B SURFACE ANTIGEN (HepBs AG) TITER* Date Drawn: _____ Lab Report Attached: <input type="checkbox"/></p>
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PLEASE READ PRIOR TO HAVING TITERS DRAWN IF YOU CANNOT PROVIDE THE DATES

You **MUST** have completed the series of three shots or your titer results will come back non-immune. The **Hepatitis B Surface Antibody (HepBs AB) Titer** cannot be drawn until 6 weeks after receiving the 3rd and final dose. The **Hepatitis B Surface Antigen (HepBs AG) Titer** can be drawn at any time and this is not quantitative as it tests for the active disease. If your HepBs AB titer comes out low or equivocal you will require one booster and if it is negative, you will need to repeat the entire series of 3 immunizations.

MIDWESTERN UNIVERSITY IMMUNIZATION REQUIREMENTS

VARICELLA (Chicken Pox)

You must provide documentation of ONE of the following for Varicella

1. Proof of having had the Chicken Pox. This must be officially documented by your health care provider, and you must have the exact dates, **MONTH, DAY & YEAR**. If you cannot provide proper documentation for having the disease then you must chose from one of the options below.

Date of Disease: _____
(month-day-year)

OR

2. Two immunizations with live virus vaccine (**the FIRST occurring at 12 months of age or older**)
The immunizations are to be 4 weeks apart

1st Date: _____ 2nd Date: _____
(month-day-year) (month-day-year)

OR

3. VARICELLA (Chicken Pox VZV IGG AB) QUANTITATIVE TITER

Date Drawn: _____ Lab Report Attached:

* DO NOT HAVE THE TITER DRAWN IF YOU HAVE NOT FOLLOWED THIS SCHEDULE! *

Varicella - Must have received 2 doses of the vaccine, administered one month apart or have had the disease. The titer cannot be drawn until 6 weeks after receiving the last immunization or recovering from the disease.

NOTE TO PHYSICIAN:

ALL of the information included on this immunization requirements form is required for the individual to matriculate as a student and be able to go on their rotations. **Some of the items required may not be standard tests performed by your office, however, the students do need to follow this form strictly and need to have all of the items completed.** If you have any questions regarding any information on this form please do not hesitate to call the Midwestern University Wellness Center at (630) 515-7233.

REQUIRED HEALTHCARE PROVIDER INFORMATION AND CERTIFICATION

(Cannot be signed by student or non-healthcare provider)

Name (please print): _____

Signature: _____ Credentials/Title: _____

Telephone Number:(_____) _____ Fax Number:(_____) _____

QUESTIONS? - PLEASE CONTACT THE MWU WELLNESS CENTER AT (630) 515-7233.
