

Last Name			First	Middle	University Identification Number		
Home Address					Preferred Phone () ()		Alternate Phone () ()
City/State/Country/Zip or Postal Code					E-mail Address		
Date of Birth (mm/dd/yyyy)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other		Enrollment term/year FA__ SP__ SU__		Citizenship <input type="checkbox"/> U.S. <input type="checkbox"/> Other (specify)	
Person to Notify in an Emergency Name:				Relationship		Contact Phone () ()	
Address of Emergency Contact (including City/State/Country/Zip or Postal Code)						Alternate Phone () ()	

All required and recommended immunizations are available at McKinley Health Center for a fee.

↓ ↓ ↓ This section must be completed by a Licensed Health Care Provider. ↓ ↓ ↓

REQUIRED IMMUNIZATIONS (dates required)

Licensed Provider: Complete Immunization documentation or attach signed physician/school immunizations.

■ **MEASLES-MUMPS-RUBELLA** – 2 shots against measles, 2 shots against rubella, and 2 shots against mumps

MMR (strongly recommended) ** 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1	mm/dd/yy	OR	MEASLES (Rubeola) 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1	mm/dd/yy
	2	mm/dd/yy			2	mm/dd/yy
Positive serum titers are also acceptable proof of immunity against measles, mumps and rubella. <input type="checkbox"/> Required lab report attached.			MUMPS 2 doses at least 28 days apart AND after 12 months of age		1	mm/dd/yy
Documentation of dates of disease IS NOT acceptable evidence of immunity against measles, mumps or rubella. **Individuals born before 1957 are exempt from MMR vaccine documentation.					2	mm/dd/yy
			RUBELLA 2 doses at least 28 days apart AND after 12 months of age		1	mm/dd/yy
					2	mm/dd/yy

■ **TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DT, DTaP, Td, Tdap) –**
At least 3 doses of diphtheria, tetanus and pertussis containing vaccine are REQUIRED. One dose MUST be Tdap.
 The last dose of vaccine (DPT, DTP, DT, DTaP, Td, Tdap) must have been administered within 10 years of the student’s enrollment date.

1 (record first shot here)	2	3
<input type="checkbox"/> DTP / DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy	<input type="checkbox"/> DTP / DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy	<input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy

■ **MENINGOCOCCAL CONJUGATE VACCINE** –Students between the ages of 16-21 must have one dose of Menactra, Menveo, Nimenrix or Aramen on or after their 16th birthday. Students age 22 and over are not required to receive the vaccine. **Meningococcal-B vaccine does not meet this requirement.**

Menactra/Menveo mm/dd/yy _____ mm/dd/yy _____ Other: Vaccine name _____ mm/dd/yy _____

RECOMMENDED IMMUNIZATIONS (complete if received)

<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
<input type="checkbox"/> HPV (Gardasil) <input type="checkbox"/> HPV (Cervarix)	1	mm/dd/yy	2	mm/dd/yy
<input type="checkbox"/> MENINGITIS B	1	<input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba mm/dd/yy	2	<input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba mm/dd/yy
<input type="checkbox"/> VARICELLA	1	mm/dd/yy	2	mm/dd/yy
<input type="checkbox"/> Had Varicella (Chickenpox)				

Required Healthcare Provider Verification: Vaccine dates must be on or prior to provider verification date.

Provider Name (print or stamp)	Signature	Date
Address		Phone

TO SUBMIT FORM: Students: Upload to MyMcKinley.illinois.edu

Providers: Fax to (217) 244-1278 or Mail to McKinley Health Center, 1109 S. Lincoln Ave., Urbana, IL 61801

Submission Deadlines: Fall - July 1, Spring - December 1, Summer - April 1