IMMUNIZATION COMPLIANCE FORM

SOUTHERN ILLINOIS UNIVERSITY
STUDENT HEALTH SERVICES

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: _____

TO BE COMPLETED BY PHYSICIAN OR OTHER HEALTHCARE PROVIDER

REQUIRED IMMUNIZATIONS

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

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.	**1** mm/dd/yy	**2** mm/dd/yy	**OR**	**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** mm/dd/yy	**2** mm/dd/yy
Positive serum titers are also acceptable proof of immunity for measles, mumps, and rubella. **Copies of reports MUST be attached.** ☐ Required lab report attached. Documentation of dates of disease IS NOT acceptable evidence of immunity against measles, mumps or rubella.				**MUMPS** 2 doses of Mumps. All doses must be on or after 1st birthday and at least 28 days apart.	**1** mm/dd/yy	**2** 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** mm/dd/yy	**2** 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 [illegible] years. Tetanus toxoid (TT) is not acceptable.

1 ☐ DTP ☐ DTaP ☐ DPT ☐ Td ☐ Tdap ☐ Adacel ☐ Boostrix mm/dd/yy	**2** ☐ DTP ☐ DTaP ☐ DPT ☐ Td ☐ Tdap ☐ Adacel ☐ Boostrix mm/dd/yy	**3** ☐ DTP ☐ DTaP ☐ DPT ☐ Td ☐ Tdap ☐ Adacel ☐ Boostrix mm/dd/yy	

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	☐ Menactra ☐ Menveo ☐ Meningococcal Conjugate

RECOMMENDED IMMUNIZATIONS

☐ **COVID-19**	**1** mm/dd/yy ☐ Moderna ☐ Pfizer ☐ J&J Janssen	**2** mm/dd/yy ☐ Moderna ☐ Pfizer	**Booster** mm/dd/yy ☐ Moderna ☐ Pfizer ☐ J&J Janssen
☐ **HEPATITIS A**	**1** mm/dd/yy	**2** mm/dd/yy	
☐ **HEPATITIS B**	**1** mm/dd/yy	**2** mm/dd/yy	**3** mm/dd/yy
☐ **HPV (Gardasil 9)** ☐ **HPV (Gardasil)** ☐ **HPV (Cervarix)**	**1** mm/dd/yy	**2** mm/dd/yy	**3** mm/dd/yy
☐ **VARICELLA** ☐ Lab test proving immunity (attach lab report)		**1** mm/dd/yy	**2** mm/dd/yy
☐ **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