Northwestern University Feinberg School of Medicine
IMMUNIZATION FORM
VISITING STUDENT ELECTIVE PROGRAM

Immunization form instructions:

1. All visiting students must have a Northwestern University immunization form filled out by a healthcare provider. There are **4 pages total**. Only Northwestern University forms will be accepted.

2. No other form may be substituted.

3. Follow all instructions and attach lab reports as requested. All applicants must attach a Hepatitis B laboratory report in **English. Failure to do so will result in an incomplete application. For students rotating between December and May, a flu shot will be required.**

4. **Do not leave any lines blank.** If attaching lab reports, indicate you are doing so by circling the sentence “Must attach a copy of lab report in English.”

5. Your healthcare provider must sign the form where requested. A Dean or Registrar’s signature will not be accepted on the Immunization Form.

6. The student (applicant) must complete page 1 and sign page 3.

7. For page 4: A PPD skin test **or** chest x-ray **or** QuantiFERON –GOLD blood test done in the **United States** within the past 6 months will be accepted.

8. All health documentation (lab reports, etc.) must be in ENGLISH.

9. Upload the completed 4-page form and required labs to VSAS. **DO NOT MAIL.**

*GLOBAL PARTNER (INTERNATIONAL) STUDENTS ONLY:*

10. If you are an international student, and have proof of a PPD skin test or chest x-ray or QuantiFERON –GOLD blood test done in the **United States** within the past 6 months, complete page 4.

11. **If you are an international student and DO NOT have proof of a PPD skin test or chest x-ray or QuantiFERON –GOLD blood test done in the United States DO NOT submit page 4.** If accepted, you will receive a QuantiFERON-GOLD blood test or chest x-ray at Northwestern.

12. TB test results performed in any country other than the United States will not be accepted. **DO NOT SUBMIT page 4 if your TB test was performed in any country other than the United States.**

**Failure to follow all instructions will result in an incomplete application.**
Visiting Medical Student Health Record

YOU MUST SUBMIT THIS FORM AND IMMUNIZATION/TB SKIN TEST VERIFICATION VIA VSAS BEFORE YOU WILL BE PERMITTED TO START YOUR PROGRAM.

1. Complete Parts I-IV, in English.
2. Make sure to record your Name and Birthdate on top of all subsequent pages.
3. Have your healthcare provider complete and sign the Immunization Verification (Part II) and PPD (TB skin test) Recording (Part IV) sections, then return it to you. You should then review the form to make certain that your immunizations are up-to-date, that your healthcare provider has completed all sections properly, and that the form is signed and dated. Update any vaccinations as necessary. All submitted documentation MUST be in English.
4. Upload completed forms with required labs to VSAS.

PART I - Student Demographics (Please print clearly or type) Today’s Date: ___/___/_____

Last Name: ___________________________ First Name: ___________________________ Middle Initial: _______ Birthday

(mm/dd/yyyy): ___/___/_______ Gender (check one): ___Male ___Female Street Address (Home):

__________________________________________________________________________ Apt#:

__________________________________________________________________________ City:

__________________________________________________________________________ State:

Country: ___________________________ Zip/Postal Code: ___________________________

Home Phone Number: (_____) _______ - _______ Country of origin (if not USA): ___________________________ How long have

you lived in the USA?: ___________________________ E-MAIL ADDRESS: ___________________________

IMPORTANT—PLEASE READ AND ANSWER! The NU Health Service will confirm receipt of this form and whether or not you have met state and Northwestern immunization requirements. PLEASE SELECT BELOW THE (ONE) METHOD BY WHICH YOU WISH TO BE NOTIFIED: _______ Email (preferred)

-Selection authorizes the Health Service to communicate entrance health requirement deficiencies via email. _______ Standard mail - Make sure you supply a valid mailing address above.

INDICATE YEAR ENTERING UNIVERSITY: 20 ___ What term? ___Fall ___Winter ___Spring ___Summer Have you ever rotated at NU before? ___Yes ___No If so, when? __________ Have you ever attended Northwestern full-time? ___No ___Yes -- which campus?

___Evanston ___Chicago List dates & programs attended full-time: ___________________________

Name of Parent(s), Spouse, or Guardian(s): ___________________________ Relationship(to student): ___________________________ Address:

__________________________________________________________________________ City/State:

__________________________________________________________________________ Postal/Zip: ___________________________ Country:

__________________________________________________________________________ Phone: (_____)-______ Alternate Phone: (_____)--______ Email Address:

__________________________

Is this person(s) your emergency contact? ___Yes ___No If “No”, please provide emergency contact information below:

Name of Emergency Contact: ___________________________ Relationship(to student): ___________________________ Address:

__________________________________________________________________________ City/State:

__________________________________________________________________________ Postal/Zip: ___________________________ Country:

__________________________________________________________________________ Phone: (_____)-______ Alternate Phone: (_____)--______

Northwestern University Feinberg School of Medicine
**PART II – IMMUNIZATION VERIFICATION**

This section (including any attached reports) must be completed by your healthcare provider and signed at the end of the section for the information to be valid under Illinois law. A healthcare provider is a physician licensed to practice medicine (M.D. or D.O.), a Licensed Nurse, or a Public Health Official. Since you will attend school in Illinois, you are required to meet Illinois requirements, which may differ from your state or country. **IF A HEALTH CARE PROVIDER DOES NOT SIGN AND DATE AT BOTTOM, ANY DATES LISTED WILL NOT BE VALID.**

**THE FOLLOWING ITEMS ARE REQUIRED FOR ALL FULL-TIME STUDENTS (Dates must be MM/DD/YYYY format):**

### MEASLES (Rubella):

- **ONE** of the following options is required.
  - 2 doses of live attenuated virus (MMR accepted) given on or after the 1st birthday, at least 28 days apart, and after 1-1-68. **MUST LIST AT LEAST 2 DATES.**
  - Date of dose #1: __/__/____
  - Dose #2: __/__/____
  - Date of illness: __/__/____

- OR 2.
  - Were either of these doses MMR vaccines? If so, which dose(s) (1 or 2)?

- OR 3.
  - Confirmation by physician's records of disease history and date of conclusive diagnosis.
  - Date of illness: __/__/____

### MUMPS:

- **ONE** of the following options is required.
  - 1 dose of live attenuated virus (MMR accepted) given on or after the 1st birthday and after 1-1-68.
  - Date of dose: __/__/____

- OR 2.
  - Confirmation by physician's records of disease history and date of conclusive diagnosis.
  - Date of illness: __/__/____

- OR 3.
  - Positive mumps serology——Must attach a copy of laboratory report in English.

### RUBELLA (German Measles):

- **ONE** of the following options is required.
  - Receipt of 1 dose of live rubella vaccine (MMR accepted) on or after the 1st birthday and after 1-1-68. Illness is NOT accepted for Rubella as immunity.
  - Date of dose: __/__/____

- OR 2.
  - Positive rubella serology——Must attach a copy of laboratory report in English.

### TETANUS/DIPHTHERIA:

- Include as many Dates (Primary Series and Booster Dose) as available.
- Primary series of 3 or more doses of either DPT, DT, or Td vaccine at intervals not less than 0, 1, & 7 months. At least three dates preferred. **Please note—Tetanus toxoid (without Diphtheria toxoid) is not acceptable per State of Illinois law.**
  - Date of dose #1: __/__/____
  - Dose #2: __/__/____
  - Dose #3: __/__/____

- Last Dose of Series or Booster Dose——must be within 10 years of Registration at Northwestern (required of all students).
  - Date of last dose: __/__/____

### HEPATITIS B:

- Serology results required.
- Positive serology for Hepatitis B surface antibody (10 IU/L or greater) done at least 4 weeks after third (or fourth) dose of vaccine. ———Must attach a copy of laboratory report in English.
- Include Dates of Vaccine if available, but dates ALONE will NOT satisfy this requirement.
  - Date of dose #1: __/__/____
  - Dose #2: __/__/____
  - Dose #3: __/__/____

### VARICELLA (CHICKEN POX):

- **One** of the following options is required.
  - 2 doses of live attenuated virus given at least 28 days apart
  - Date of dose #1: __/__/____
  - Dose #2: __/__/____

- OR 2.
  - Confirmation by physician's records of disease history and date of conclusive diagnosis.
  - Date of illness: __/__/____

- OR 3.
  - Positive varicella serology——Must attach a copy of laboratory report in English.

### RECOMMENDED for all students: MENINGOCOCCAL

- **THIS IS NOT A REQUIREMENT!!**
- 1 dose of meningococcal vaccine within 3 years of registration.
  - Date of dose: __/__/____

*PPD (TB skin test) information recorded on page 4 (Part IV) of this form.*

**Health care provider information and signature (Required)**

<table>
<thead>
<tr>
<th>Name of health care provider (PRINTED)</th>
<th>Title (Physician, Nurse, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of health care provider</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(__________________________)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City/State</th>
<th>Zip</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Northwestern University Feinberg School of Medicine
Exemptions from Vaccine requirements may be made for the following circumstances:

- **Medical Contraindications:** a written, signed and dated statement from a healthcare provider stating the vaccine(s) that is(are) contraindicated, the medical condition or circumstances that contraindicates such immunization(s), and duration of the medical condition that prevents administering the vaccine(s). This statement will not be accepted if it does not meet the standards of care at Northwestern University.
- **Religious Exemption:** a written, signed, and dated statement from the church, student or the student's parent or guardian, if the student is a minor, documenting their objection based upon religious tenets or practice of a recognized church or religious organization, of which the student is an adherent or member. Please request and complete the "Religious Waiver and Release" form.
- **Pregnancy or Suspected Pregnancy:** a signed statement from a physician stating that the student is pregnant or is suspected of being pregnant. Pregnancy exemptions are only applicable to Measles, Mumps, Rubella, and Varicella requirements.
- **Age Exemption:** persons born before January 1, 1957 are considered immune from Measles, Mumps and Rubella.

Anyone with a Vaccination Exemption may be excluded from the University campus(es) in the event of a Measles, Mumps, Rubella, Diphtheria, or Varicella outbreak in accordance with Public Health Regulations.

**PART III – PERMISSION FOR TREATMENT BY NORTHWESTERN UNIVERSITY HEALTH SERVICE**

All students are advised to always carry their NU identification cards and the name, address, and policy number of their medical insurance. Northwestern University reserves the right to have any student admitted to the University examined by a Health Service physician. Please sign and date the following.

**PERMISSION FOR TREATMENT OF PERSONS AGE 18 YEARS AND OVER**

If you are 18 years of age or older and have completed the medical history sections, Parts II & III, then you must sign this section of the form.

**No treatment will be provided if a signed permission for treatment form is not on file at the Health Service.**

I certify that the foregoing information is true and complete to the best of my knowledge. I realize that the information I have given in the medical history section is confidential and for the use of the Health Service staff. I give permission to Northwestern University to furnish such diagnostic, therapeutic, voluntary immunization, and operative procedures and transportation as may be deemed necessary on my behalf. I am 18 years of age or older. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment or examination by the Health Service staff.

__________________________
Student's Signature
__________________________
Date

**DO NOT WRITE BELOW THIS LINE — FOR HEALTH SERVICE USE ONLY!**

<table>
<thead>
<tr>
<th>Health History</th>
<th>Rubella</th>
<th>PPD</th>
<th>Varicella</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permission</td>
<td>DT Booster</td>
<td>PPD Visit (5-9mm result)</td>
<td>Hep B Vaccine - #</td>
</tr>
<tr>
<td>Measles #1 #2</td>
<td>DT series: #1 #2</td>
<td>Chest X-Ray</td>
<td>Hep B Titer</td>
</tr>
<tr>
<td>Mumps</td>
<td>TB Screening</td>
<td>+PPD, Physician Visit</td>
<td>Provider Signature</td>
</tr>
</tbody>
</table>

Notes: ____________________________________________

Date student notified of compliance status: / / By (initials): 

Method of notification: Email Postcard

Date of compliance: / / Record updated by (initials): 

Student complete until: / /
Part IV - PPD (TB skin test) Recording

All students in a health care-related program (e.g., Medical, Prosthetics-Orthotics, PT) must show proof or have a PPD. PPD's (TB skin test) must be done in the USA within 6 months prior to registration at Northwestern and MUST be read by a health care provider within 48-72 hours of administration to be valid.

Tests done outside the USA will not be accepted.

Last Name (student): _______________________________ First Name: _______________________________

Date of Birth (MM/DD/YYYY): _______________________

Health Care Provider's Section:

This section MUST be completed and signed by a licensed health care provider. Please provide the information below:

Date test administered (MM/DD/YYYY): _______________________

Date test read (MM/DD/YYYY): _______________________

Reading/Result in millimeters induration: ________________

If reading is 5 - 9mm, please ask student the following questions (Circle “Yes” or “No”):
1) History of an abnormal chest x-ray? Yes No
2) History of TB exposure? Yes No
3) History of Immune Suppression? Yes No

If reading is 10mm or greater, student must provide a report of a chest x-ray done in the USA within 6 months prior to registration at Northwestern, and are required to meet with a University Health Service physician.

Name of health care provider (printed): _______________________________

Signature of provider ______________ Date ______________

Provider’s phone number: (____________) ________________________

Address of provider/ clinic (or address stamp): ________________