

## 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 <u>4 pages total</u>. 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.**
- 4. **<u>Do not leave any lines blank.</u>** 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 <u>or</u> chest x-ray <u>or</u> QuantiFERON –GOLD blood test done in the <u>United States</u> 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 <u>United States within the past 6 months</u>, 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. **<u>DO</u>** 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.
- 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 <u>MUST be in English</u>.
- 4 Upload completed forms with required labs to VSAS.

<u>PAR</u>	<u> </u>	learly or type) Today's Date:	
Last Name:	First Name:	Middle Initia	ıl: Birthdate
(mm/dd/yyyy):/	Gender (check one):MaleFemale Street Addres	ss (Home):	
	Apt#: City: _	State:	
	Country: Zip/Postal C	ode:	
Home Phone Number: ()	Country of origin (if not USA):	:	How long have
you lived in the USA?:	E-MAIL ADDRESS:		
	PLEASE SELECT BELOW THE (ONE) METHOD BY W	HICH YOU WISH TO BE NOTIFIED:	
Northwestern immunization requirementsSelection authorizes the Health Service to valid mailing address above.	PLEASE SELECT BELOW THE (ONE) METHOD BY W to communicate entrance health requirement deficiencies  IIVERSITY: 20 What term?FallWinter _	via email Standard mail - Make	sure you supply a
Northwestern immunization requirementsSelection authorizes the Health Service to valid mailing address above.  INDICATE YEAR ENTERING UN before?YesNo _ If so, when?	, ,	via email Standard mail - MakeSpringSummer Have you ever n full-time?NoYes which	e sure you supply a
Northwestern immunization requirementsSelection authorizes the Health Service to valid mailing address above.  INDICATE YEAR ENTERING UN before?YesNo	o communicate entrance health requirement deficiencies  IIVERSITY: 20 What term?FallWinter _  Have you ever attended Northwester	via email Standard mail - MakeSpringSummer Have you ever n full-time?NoYes which	rotated at NU
Northwestern immunization requirementsSelection authorizes the Health Service to valid mailing address above.  INDICATE YEAR ENTERING UN before?YesNo	IIVERSITY: 20 What term?FallWinter Have you ever attended Northwester & programs attended full-time:	via email Standard mail - MakeSpringSummer Have you ever n full-time?NoYes which	rotated at NU campus? Address:
Northwestern immunization requirementsSelection authorizes the Health Service to valid mailing address above.  INDICATE YEAR ENTERING UN before?YesNo	IIVERSITY: 20 What term?FallWinter _ Have you ever attended Northwester programs attended full-time:	via email Standard mail - Make SpringSummer Have you ever n full-time?NoYes which  Relationship(to student): Postal/Zip:	e sure you supply a r rotated at NU campus? Address: Country:
Northwestern immunization requirementsSelection authorizes the Health Service to valid mailing address above.  INDICATE YEAR ENTERING UN before?YesNo	IIVERSITY: 20 What term?FallWinter Have you ever attended Northwester & programs attended full-time: n: City/State:	via email Standard mail - Make SpringSummer Have you ever in full-time?NoYes which  Relationship(to student):  Postal/Zip: Email Addr	e sure you supply a r rotated at NU campus? Address: Country:
Northwestern immunization requirementsSelection authorizes the Health Service to valid mailing address above.  INDICATE YEAR ENTERING UN before?YesNo	IIVERSITY: 20 What term?FallWinter Have you ever attended Northwester & programs attended full-time: n: City/State: Alternate Phone: (	via email Standard mail - Make SpringSummer Have you ever in full-time?NoYes which  Relationship(to student):  Postal/Zip: begin and contact information below:	e sure you supply a r rotated at NU campus? Address: Country: ress:
-Selection authorizes the Health Service to valid mailing address above.  INDICATE YEAR ENTERING UN before?YesNo	IIVERSITY: 20 What term?FallWinter Have you ever attended Northwester & programs attended full-time:  City/State: () Alternate Phone: (	via email Standard mail - Make SpringSummer Have you ever in full-time?NoYes which  Relationship(to student):  Postal/Zip:	e sure you supply a r rotated at NU campus? Address: Country: ress:

Northwestern University Feinberg School of Medicine

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08/07 abh

Last Name	e (student):	First	Name:		Birthdate:
	P/	ART II – IMMUNI	ZATION VERIF	ICATION	
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 health care 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 FOL	LOWING ITEMS ARE REQ	UIRED FOR ALL FU	JLL-TIME STUDE	NTS (Dates	must be MM/DD/YYYY format):
MEASL	ES (Rubeola): ONE of the	following options is r	equired.		
1.	2 doses of <b>live</b> attenuated virus (I days apart, and after 1-1-68. MUS	MMR accepted) given on o	or after the <b>1st</b> birthday <b>'ES</b> .	y, at least 28	Date of dose #1://
00.0	Were either of these doses MMF	•	.,, ,		Dose #2:/
OR 2. OR 3.	Confirmation by physician's record				Date of illness://
	Positive measles serologyM		oratory report in Engi	isn.	
	S: ONE of the following optic	ons is required.			
1.	1 dose of live attenuated virus (M 1-1-68.				Date of dose://
OR 2.	Confirmation by physician's record	•			Date of illness://
OR 3.	Positive mumps serology <b>M</b> u	ist attach a copy of labo	ratory report in Englis	sh.	
RUBEL	LA (German Measles): ON	<b>IE</b> of the following op	otions is required.		
1.	Receipt of 1 dose of live rubella v		on or after the <b>1st</b> birthe	day and after	Date of dose:/
OR 2.	Positive rubella serologyMu	ist attach a copy of labo	ratory report in Engli	sh.	
TETAN	IUS/DIPHTHERIA: Include	as many Dates (Prin	nary Series and Bo	ooster Dose)	as available
months.	series of 3 or more doses of either At least three dates preferred. (PI le per State of Illinois law!)				Date of dose #1://
	se of Series or Booster Dose of ALL students)	must be within 10 year	ars of Registration at	Northwestern	Date of last dose://
HEPAT	TITIS B: Serology results re	equired.			
	serology for Hepatitis B surface antilose of vaccine.			after third (or	Date of dose #1://
Include I	Dates of Vaccine if available, but o	dates ALONE will NOT s	atisfy this requiremer	nt.	Dose #3:/
VARIC	ELLA (CHICKEN POX): On	<b>e</b> of the following op	tions is required.		
1.	2 doses of live attenuated virus g		<u> </u>		Date of dose #1://
OR 2.	Confirmation by physician's record	ds of disease history and	date of conclusive diag	nosis.	Date of illness://
OR 3.	Positive varicella serology	lust attach a copy of lab	oratory report in Eng	lish.	
RECO	MMENDED for all students: N	MENINGOCOCCAL	(THIS IS NOT A	REQUIREME	ENT!!)
	f meningococcal vaccine within 3 ye				Date of dose://
<u>Health c</u>	are provider information a	<u>nd signature</u> (Requi	ired)	Ac	art IV) of this form.
	ealth care provider (PRINTED)  of health care provider		le (Physician, Nurse, et	IC.)	
oignature C	n nealth care provider	Dai	<del>C</del>	(	
Street Addr	ress	City/State	Zip	Phone number	/ r

_ast Name (student):		First Name:	Birthdate:
Exemptions from Vaccine requireme	ents may be made for the follow	lowing circumstances:	
contraindicated, the medical prevents administering the University.  • Religious Exemption: a warminor, documenting their old student is an adherent or many Pregnancy or Suspected pregnant. Pregnancy exemuse.  • Age Exemption: persons by	al condition or circumstances vaccine(s). This statement written, signed, and dated state bjection based upon religiounember. Please request ance Pregnancy: a signed state aptions are only applicable to born before January 1, 1957 tion may be excluded from	s that contraindicates such imr will not be accepted if it does in the tement from the church, stude is tenets or practice of a recog if complete the "Religious Waix ment from a physician stating of Measles, Mumps, Rubella, a are considered immune from the University campus(es) i	that the student is pregnant or is suspected of being and Varicella requirements.  Measles, Mumps and Rubella.  in the event of a Measles, Mumps, Rubella, Diphthe
	or Varicella outbreak in	accordance with Public Hea	alth Regulations.
PART III _ DEDMICO	SION FOR TREATME	NT RY NORTHWESTE	RN UNIVERSITY HEALTH SERVICE
	ern University reserves	s the right to have any s	e name, address, and policy number of their tudent admitted to the University examined
PERMISS	SION FOR TREATME	NT OF PERSONS AGE	18 YEARS AND OVER
( 40		aria (1997)	0.111. the consequence of the con
			& III, then you must sign this section of the form.  is not on file at the Health Service.
· · · · · · · · · · · · · · · · · · ·			lize that the information that I have given in the medical
			to Northwestern University to furnish such diagnostic
herapeutic, voluntary immunization, a	and operative procedures ar	nd transportation as may be de	eemed necessary on my behalf. I am 18 years of age of
		cience, and I acknowledge that	at no guarantees have been made to me as to the resu
of treatment or examination by the He	ealth Service staff.		
Student's Signature		Date	
DO NOT W	RITE BELOW THIS	LINE-FOR HEALT	H SERVICE USE ONLY!
		ompliance with entrance red	
Date processed (mm/dd/\aaa/)-	/B <b>y</b> (i	nitials): COMP	LIANT w/requirements?YESNO
-a.c processeu (mm/au/yyyy)			
f "NO", Please indicate deficiency			
f "NO", Please indicate deficiency Health History	Rubella	PPD	Varicella
f "NO", Please indicate deficiency  Health History  Permission	Rubella DT Booster	PPD Visit (5-9r	mm result)Hep B Vaccine #
f "NO", Please indicate deficiency Health History Permission Measles#1#2	Rubella DT Booster DT series:#1#2	PPD Visit (5-9r Chest X-Ray	mm result) — Hep B Vaccine # — Hep B Titer
f "NO", Please indicate deficiency Health History Permission Measles#1#2 Mumps	RubellaDT Booster DT series:#1#2TB Screening	——PPD Visit (5-9r ——Chest X-Ray ——+PPD, Physicia	mm result)Hep B Vaccine # Hep B Titer an VisitProvider Signature
f "NO", Please indicate deficiency Health History Permission Measles#1#2 Mumps	RubellaDT Booster DT series:#1#2TB Screening	PPD Visit (5-9r Chest X-Ray	mm result)Hep B Vaccine # Hep B Titer an VisitProvider Signature
f "NO", Please indicate deficiency Health HistoryPermissionMeasles#1#2Mumps  Notes:	RubellaDT Booster DT series:#1#2TB Screening	——PPD Visit (5-9r ——Chest X-Ray ——+PPD, Physicia	mm result)Hep B Vaccine # Hep B Titer an VisitProvider Signature Date Form Received (stamp)
f "NO", Please indicate deficiency Health History Permission Measles#1#2 Mumps	RubellaDT Booster DT series:#1#2TB Screening	——PPD Visit (5-9r ——Chest X-Ray ——+PPD, Physicia	mm result)Hep B Vaccine # Hep B Titer an VisitProvider Signature Date Form Received (stamp)
f "NO", Please indicate deficiency Health HistoryPermissionMeasles#1#2Mumps  lotes:	RubellaDT Booster DT series:#1#2TB Screening	——PPD Visit (5-9r ——Chest X-Ray ——+PPD, Physicia	mm result)Hep B Vaccine # Hep B Titer an VisitProvider Signature Date Form Received (stamp)

Student complete until: \_\_\_\_/\_\_\_/\_

# Northwestern University Feinberg School of Medicine

Visiting Student Programs
Augusta Webster Office of Medical Education
303 East Chicago Avenue, Ward 1-003
Chicago, IL 60611 USA

### Part IV - PPD (TB skin test) Recording

All students in a healthcare-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 <u>and MUST</u> be read by a <u>health care provider</u> 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 libelow:	censed health care provider. Please provide the information		
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 follow  1) History of an abnormal chest x-ray?  2) History of TB exposure?  3) History of Immune Suppression?  Yes If reading is 10mm or greater, student must provide a registration at Northwestern, and are required to meet to	No No No report of a chest x-ray done in the USA within 6 months prior to		
Name of health care provider (printed):			
Signature of provider  Provider's phone number: ()_	Date		
, , , , , , , , , , , , , , , , , , , ,			
Address of provider/clinic (or address stamp):			