MEADVILLE LOMBARD
THEOLOGICAL SCHOOL

2016/2017 Student Immunization Requirements

The State of Illinois code, Reference: (110 ILCS 20) College Student Immunization Act, requires students to provide proof of immunity: Measles (Rubeola), Mumps, Rubella (German measles), and Tetanus/ Diphtheria.

CPE sites will require students to have immunization records in order as well. You should plan to get an extra copy of your immunization records from your doctor's office/clinic.

Pages 2-3 of the immunization form (or official copies of lab results from the doctor's office) must be returned to the Director of Student Records/Registrar by: **May 30, 2016 for Summer 2016 and August 22, 2016 for Fall 2016.** Failure to return your immunization form can result in your being placed on restriction, which will deny you access to Meadville Lombard facilities and future class enrollments.

Forms will be accepted via mail or hand-delivered to:

Meadville Lombard Theological School - Student Records
610 S Michigan Ave, Chicago, IL 60605

Instructions: please read carefully:

- **HEALTH CARE PROVIDER:** A licensed healthcare provider must complete the immunization form. A health care provider is: a physician licensed to practice (M.D. or D.O.), a Licensed Nurse, or a Public Health Official.
- **ENGLISH:** All immunization forms and copies of laboratory reports must be submitted in English. Translations of non-English documents must be certified. It is acceptable to have an English translation of the documents certified as accurate by a member of the University of Chicago community who is fluent in the document's original language.
- **MEASLES, MUMPS, and RUBELLA:** Vaccines for Measles, Mumps, and Rubella, must be given on or after 12 months of age (on or after the student's first birthday). **Two (2) Measles (Rubeola) vaccines, separated by at least 28 days, are required**. For measles vaccines given before 1968, proof must be submitted that a live-virus vaccine was administered. History of disease is not acceptable as proof of immunity for Rubella. Lab (serologic) evidence of mumps immunity and titers are required for proof of immunity in those who have a history of disease.
- **TETANUS**: All students must show proof of vaccination for Tetanus and Diphtheria within the past ten years. For students who currently require vaccination, the Tdap (tetanus, diphtheria and acellular pertussis) vaccine to replace a single dose of Td is strongly recommended, but not required. **Note: If your Tetanus expires (10 years since last dose) while attending school you will be required to obtain a booster vaccination to remain compliant.**
- **INTERNATIONAL STUDENTS: Must provide three (3) dose dates for Tetanus/diphtheria immunizations**. The 1st and 2nd doses must be separated by a minimum of 28 days. The 2nd and 3rd doses must be separated by a minimum of 6 months. For students who currently require vaccination, the Tdap (tetanus, diphtheria and acellular pertussis) vaccine to replace a single dose of Td is strongly recommended, but not required.
- • MENINGOCOCCAL: (Recommended but not required) College students, particularly freshmen living in dormitories, have a higher risk of getting this contagious disease. Meningitis is a serious disease which afflicts about 2,500 Americans and 10-15% of them die yearly. The meningitis vaccine does not protect against all forms of meningococcal viruses.

• HEPATITIS B: (Recommended but not required) Hepatitis B is a serious infectious disease caused by a virus that attacks the liver. The hepatitis B virus (HBV) can cause life-long infection leading to cirrhosis (scarring) of the liver, liver cancer, and/or liver failure. There is no cure for hepatitis B, but the infection can be prevented by vaccination.

• VARICELLA: (Recommended but not required) Compared to children, adolescents and adults are at increased risk for more severe disease complications from varicella (chickenpox). If you have not had chickenpox or do not have evidence of immunity to varicella, it is recommended that you receive the varicella vaccination series (2 doses, 30 days apart).

- **EXEMPTIONS:** Anyone with a vaccine exemption may be excluded from the University/College in the event of a Measles, Mumps, Rubella or Diphtheria outbreak in accordance with public health law.
    - **MEDICAL CONTRAINDICATIONS**: a written, signed, and dated statement from a physician stating the vaccine that is contraindicated, the nature, and duration of the medical condition that contraindicates the vaccine(s). This statement will not be accepted if it does not meet the standards of care at The University of Chicago Hospitals. Submit this statement to the SCC Immunization Program.
    - **PREGNANCY OR SUSPECTED PREGNANCY**: a signed statement from a physician stating the student is pregnant or pregnancy is suspected. Pregnancy exemptions are applicable only to Measles, Mumps, and Rubella requirements. Submit this statement to the Student Records Office.

• **AGE EXEMPTION**: persons born before January 1, 1957 are considered immune to Measles, Mumps, and Rubella. Requirements may be met by the submission of a copy of the student's birth certificate, driver's license; State issued ID, or passport identifying the birth date. Submit this statement to the Student Records Office.
• **RELIGIOUS EXEMPTION**: a written, signed, and dated statement by the student detailing the student's objection to immunization on religious grounds. Request for religious exemptions will be forwarded for review and only be granted by the Registrar. Submit this statement to the Student Records Office.
• **OFF-CAMPUS EXEMPTION**: persons not participating in campus-based classes or school-sponsored activities at Meadville Lombard Theological School at any time during the 2016/17 academic year are **EXEMPT** from providing proof of immunizations.

DEADLINE TO RESPOND IS AUGUST 22, 2016

Academic Year 2016/2017 Student ID#_____

I, _____(student name) ,certify that I qualify for the _____ exemption(s) and am not required to complete Part II of the Immunization Form (age exemptions require proof of age as noted above).

Signature_____ Date _____

Meadville Lombard Student Immunization Record

Part I:

Last Name: _____ First Name: _____ MI: _____

Address: _____

Date of Birth: _____/_____/_____ Sex: _____ Social Security # (last four): XXX-XX-_____

Preferred Telephone Number: _____ Email: _____

Part II:

This section is to be completed by a Healthcare provider. All dates must include MONTH and YEAR.

MMR # 1 Date of Vaccine ____/_____/_____
(Must be given on or after 12 months of age-1st birthday)

MMR # 2 Date of Vaccine ____/_____/_____
(Must be given at least 28 days after 1st vaccine)

OR

If individual vaccines were received for Measles, Mumps, and Rubella-please complete this section.

Measles (*Rubeola*) Vaccine Date of Vaccine # 1 ___/____/_____
Date of Vaccine # 2 ___/___/_____

Rubella (*German measles*) Vaccine Date of Vaccine # 1 ___/___/_____

Mumps Vaccine Date of Vaccine # 1 ___/___/_____
Date of Vaccine # 2 ___/___/_____

**** Childhood infections of any of the above must be documented by Physician's record.**
If proof of vaccine cannot be provided, a student may obtain a blood titer to confirm immunity of any of the above. A copy of the laboratory test in English must be submitted.

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Part III:

This section is to be completed for **US Citizens/permanent residents** only.

Tetanus/ Diphtheria Vaccine Date of Vaccine ___/___/_____
(Given within the last 10 years) Td *or* Tdap

This section is to be completed by **international students** only.
You must provide three (3) documented doses of Td, the last dose given within the last 10 years.

Date of 1st Vaccine ___/___/_____ Td *or* Tdap
Date of 2nd Vaccine___/___/_____ Td *or* Tdap
Date of 3rd Vaccine___/___/_____ Td *or* Tdap

Part IV:

Recommended Vaccines: *Vaccines encouraged, but not required for admission.*

Meningitis Vaccine Date of Vaccine ___/____/_____

Hepatitis B Vaccine Date of Vaccine(s)
#1 ___/___/_____
#2 ___/___/_____
#3 ___/___/_____

Varivax/Varicella (Chickenpox) Date of Vaccine # 1 ___/___/_____
Date of Vaccine # 2 ___/___/_____

Healthcare Provider Certification

*Provider(s) Signature_____

*Provider(s) Printed Name_____

Address_____

*Phone Number_____

*required

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