



# HEBREW THEOLOGICAL COLLEGE

A MEMBER OF TOURO UNIVERSITY

Office of the Registrar  
Hebrew Theological College  
7135 N Carpenter Road  
Skokie, IL 60077

(847) 982-2500  
(847) 745-0200 fax  
bachrach@htc.edu

## HTC STUDENT MEDICAL IMMUNIZATION FORM

**PART I:** To be completed by all students attending classes on-campus at Hebrew Theological College.

FOR OFFICE USE	
<input type="checkbox"/> Complete	<input type="checkbox"/> Incomplete
<input type="checkbox"/> Updated	<input type="checkbox"/> Duplicate
<input type="checkbox"/> RC _____	

T  
University Identification Number (UIN) \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name M.I. Date of Birth

\_\_\_\_\_  
Address (number and street) City State Zip Code Home Telephone Number

Gender M  F  Term of Admission  Fall (Aug.)  Spring (Jan.)  Summer Year of Admission \_\_\_\_\_

I, the undersigned, authorize Hebrew Theological College to release my immunization record to the Illinois Department of Public Health (IDPH), or its designated representative, in the event of a health or safety emergency and/or for compliance audits by the IDPH or another state or federal agency duly authorized by law to conduct compliance audits of Hebrew Theological College.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please read the instructions on the reverse side of this form before having it completed by a healthcare provider.

**PART II:** To be completed and signed by a healthcare provider<sup>1</sup>. All dates must include month, day, and year. (Check appropriate box)

- Students born before 1957 should see #7 on reverse side.

### Measles (Rubeola)

1. Immunization with live virus vaccine?  
(Two doses are required and must be given at least 28 days apart. Both doses given in 1968 or later, and given on or after first birthday.)

\_\_\_\_\_  
Date 1 Date 2

2. Disease confirmed by physician's records?

\_\_\_\_\_  
Date of illness Signature of Physician

3. Immunity confirmed by blood titer?

\_\_\_\_\_  
Date of test  Attached copy of laboratory Report

4. Exemption?

Attach physician's statement of medical contraindication with duration of medical condition.

### Rubella (German Measles)

1. Immunization with live virus vaccine?  
(Two doses are required and must be given at least 28 days apart. Both doses given in 1968 or later, and given on or after first birthday.)

\_\_\_\_\_  
Date 1 Date 2

2. Disease confirmed by physician's records?

\_\_\_\_\_  
Date of illness Signature of Physician

3. Immunity confirmed by blood titer?

\_\_\_\_\_  
Date of test  Attached copy of laboratory Report

4. Exemption?

Attach physician's statement of medical contraindication with duration of medical condition.

### Mumps

1. Immunization with live virus vaccine?  
(Two doses are required and must be given at least 28 days apart. Both doses given in 1968 or later, and given on or after first birthday.)

\_\_\_\_\_  
Date 1 Date 2

2. Disease confirmed by physician's records?

\_\_\_\_\_  
Date of illness Signature of Physician

3. Immunity confirmed by blood titer?

\_\_\_\_\_  
Date of test  Attached copy of laboratory Report

4. Exemption?

Attach physician's statement of medical contraindication with duration of medical condition.

### Tetanus and Diphtheria (TD or DT or DPT)

Note: Tetanus Toxoid (TT) is not acceptable

1. Primary series completed?  
(At least three doses are required. One must be "Tdap." The most recent must be within last 10 years)

\_\_\_\_\_  
Date 1 Tdap  Date 2 Tdap  Date 3 Tdap

If serious doubt exists about the completion of a primary three-dose series, two doses of combined (TD) toxoids should be given one month apart, followed by a third dose in 6 months.

2. Exemption?

Attach physician's statement of medical contraindication with duration of medical condition.

### Meningitis

1. Primary dose completed?  
(Required for students under age 22. Must be given on or after 16th birthday)

\_\_\_\_\_  
Date 1 Date 2

2. Exemption?

Attach physician's statement of medical contraindication with duration of medical condition.

Health care provider verifying information for Part II.

Date \_\_\_\_\_

Name (Print) \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

<sup>1</sup>-Physician licensed to practice medicine in all of its branches (MD or DO), a local health authority, registered nurse employed by a school, college, or university, or a department recognized vaccine provider.



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## INSTRUCTIONS FOR COMPLETION OF THE HTC STUDENT MEDICAL IMMUNIZATION FORM

### MUST BE COMPLETED AND RETURNED PRIOR TO THE STUDENT'S FIRST ENROLLMENT

**NOTE:** The Illinois Department of Public Health requires incoming new students living in on-campus housing to document immunity to measles, rubella, mumps, tetanus/diphtheria, and meningitis.

**PART I** - To be completed by all students attending classes on-campus at Hebrew Theological College.

All students who are admitted or readmitted to Hebrew Theological College must submit this form. A healthcare provider (physician licensed to practice medicine in all of its branches [MD or DO]; a local health authority; registered nurse employed by a school, college, or university; or a department-recognized vaccine provider) must validate current immunization records in PART II. The completed form must be received by the Office of Medical Immunization Records at Hebrew Theological College no later than the first day of classes of the term. Failure to return this form and/or provide proof of immunity to the vaccine-preventable diseases may result in the student not being authorized to register for the next term.

(P.A. 85-1315)

The following are acceptable as documentation of immunization: (1) this form, (2) the Certificate of Child Health Examination form (high school record), and (3) a Certificate of Immunity showing the type of vaccine, date of each dose (month/day/year), the name of the physician or clinic that administered the vaccine, the phone number, and the address. ALL RECORDS must be verified or authenticated by a physician, registered nurse, or public health official and to be date- and dose-specific. Include University Identification Number (UIN) on all documents.

A student with a vaccine exemption may be excluded from the university/college in the event of a measles, rubella, mumps, diphtheria, or meningitis outbreak in accordance with public health recommendations.

All records not in English must be accompanied by a certified translation.

**Students should keep a copy of this form for their personal health records. All originals submitted to the Office of Immunization Records will be destroyed after imaging. For additional information, the student may call the Office of Medical Immunization Records at (847) 982-2500.** Compliance can be viewed online at the Registrar's web site under "Student Records."

**PART II**- Must be completed and signed by a healthcare provider.

1. All dates must include MONTH, DAY, and YEAR if it cannot otherwise be determined that the specific vaccine(s) was administered at the minimally acceptable age or dosage interval.
2. All laboratory evidence of immunity must be accompanied by a copy of the laboratory report.
3. All live virus vaccines must have been given on or after the first birthday.
4. The minimum time between each dose of live measles virus vaccine must be at least 28 days.
5. History of rubella disease is not acceptable as proof of immunity.
6. Mumps titer is only acceptable as proof of immunity if the laboratory test used was a neutralization, enzyme-linked immunosorbent assay (ELISA or EIA) or radial hemolysis antibody test. A four-fold rise in antibody titer between appropriately spaced acute and convalescent sera is also acceptable.
7. Individuals born prior to 1957 can be considered immune to measles, mumps, rubella, and polio. Such individuals are also exempt from the state law requiring immunization for tetanus/diphtheria.
8. The following exemptions will be accepted and statements must accompany this record:
  - MEDICAL CONTRAINDICATIONS—A written, signed, and dated statement from a physician stating the specific vaccine or vaccines contraindicated and duration of medical condition that contraindicates the vaccine(s).
  - PREGNANCY OR SUSPECTED PREGNANCY—A signed statement from a physician stating the student is pregnant or pregnancy is suspected and an approximate due date.

**KEEP A COPY FOR YOUR RECORDS.  
ORIGINALS WILL BE DESTROYED AFTER IMAGING.**