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McKINLEY HEALTH CENTER
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

IMMUNIZATION HISTORY

Submit completed Immunization History and Medical History forms to:

McKinley Health Center 1109 South Lincoln Avenue Urbana, IL 61801. Phone: (217) 333-2702 - Fax: (217) 244-1278

All forms must be submitted no later than July 1 for Fall, December 1 for Spring, and April 1 for Summer Semesters

(International Students: If you are unable to fax forms by the deadline above, bring forms with you to campus.)

► **International Students:** Tuberculosis screening will be performed at McKinley Health Center when you arrive on campus. Fax completed Immunization History and Medical History forms to: (217) 244-1278 and bring a copy with you to campus.

► **Medical/Religious Exemption:** Acceptable medical exemptions are pregnancy, suspected pregnancy, allergies to vaccine, immunosuppression, or severe illness and must include a physician's letter. Contact the Dean of Students office for religious exemption.

Last Name		First	Middle	University Identification Number	
Home Address				Preferred Phone ()	
City/State/Country/Zip or Postal Code				Alternate Phone ()	
Date of Birth (mm/dd/yyyy)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Country of Birth		E-mail Address
Citizenship <input type="checkbox"/> U.S. <input type="checkbox"/> Other (specify)					Primary spoken language
Semester of FIRST Enrollment and specify year: <input type="checkbox"/> Fall (year)_____ <input type="checkbox"/> Spring (year)_____ <input type="checkbox"/> Summer (year)_____					

IMMUNIZATIONS REQUIRED BY ILLINOIS LAW (dates required)

Licensed Provider: Complete Immunization documentation or attach signed physician/school immunizations.

■ **MEASLES-MUMPS-RUBELLA** – 2 shots against measles, 1 shot against rubella, and 1 shot against mumps (2 recommended)

MMR (strongly recommended) 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1	mm/dd/yy	OR	MEASLES (Rubeola) 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967.	1	mm/dd/yy	Documentation of dates of disease serves as acceptable evidence of immunity against measles and mumps, but not rubella. <input type="checkbox"/> Required documentation attached.
	2	mm/dd/yy		2	mm/dd/yy		
Positive serum titers are also acceptable proof of immunity against measles, mumps and rubella. <input type="checkbox"/> Required lab report attached.				MUMPS after 12 months of age	1	mm/dd/yy	
			RUBELLA after 12 months of age	1	mm/dd/yy		

■ **TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DT, DTaP, Td, Tdap)**

Domestic students: record of at least one tetanus/diphtheria shot within 10 years of enrollment is required.

International students: record of at least three tetanus/diphtheria shots, one within 10 years of enrollment, is required.

1 <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> DTP mm/dd/yy	2 <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> DTP mm/dd/yy	3 <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> DTP mm/dd/yy
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IMMUNIZATIONS (Recommended)–Please indicate immunizations received and provide dates.

NOTE: Meningococcal meningitis is a potentially fatal, vaccine-preventable illness. We recommend the Meningococcal Conjugate Vaccine for all students 21 and younger. A second vaccine should be given if the first vaccine was given before age 16. This vaccine is available at the Health Center for a fee.

<input type="checkbox"/> MENINGOCOCCAL CONJUGATE VACCINE	1	mm/dd/yy	2	mm/dd/yy	
<input type="checkbox"/> HEPATITIS A	1	mm/dd/yy	2	mm/dd/yy	
<input type="checkbox"/> HEPATITIS B	1	mm/dd/yy	2	mm/dd/yy	3 mm/dd/yy
<input type="checkbox"/> HPV (Gardasil) <input type="checkbox"/> HPV (Cervarix)	1	mm/dd/yy	2	mm/dd/yy	3 mm/dd/yy
<input type="checkbox"/> VARICELLA	1	mm/dd/yy	2	mm/dd/yy	<input type="checkbox"/> Had Varicella (Chickenpox)

Required Healthcare Provider Verification

Provider Name (print or stamp)	Signature	Date	for McKinley use only Date exemption ends: ____/____/____ <input type="checkbox"/> allergy <input type="checkbox"/> illness <input type="checkbox"/> pregnancy
Address		Phone	



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MEDICAL HISTORY – to be completed by student

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International Students: If you are unable to fax forms by the deadline above, bring forms with you to campus.

Last Name	First	Middle	Date of Birth (mm/dd/yyyy)	University Identification Number
ALLERGIES: <input type="checkbox"/> Yes <input type="checkbox"/> No Please check those to which you are allergic: <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine				
Other drug allergies (specify)_____				
Environmental allergies:_____				
I take allergy shots (specify allergens and frequency)_____				
Please list any over-the-counter or prescription drugs (include herbals and birth control pills) that you are taking.				

Personal Health History *Please check conditions/diseases you have had. If none apply, check this box*

<p>General</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Malaria <input type="checkbox"/> Obesity <input type="checkbox"/> Sleeping Disorder <p>Cardiovascular</p> <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Hypertension <p>Respiratory</p> <input type="checkbox"/> <i>Asthma</i> <input type="checkbox"/> Bronchitis/Pneumonia <input type="checkbox"/> Tuberculosis	<p>Head / Ears / Eyes / Nose / Throat</p> <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Nasal Disorders/Trauma <input type="checkbox"/> Oral/Mouth Disorder <input type="checkbox"/> Visual Impairment <p>Gastrointestinal</p> <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Crohn Disease <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Dyspepsia (heartburn) <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> GERD <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Ulcerative Colitis	<p>Genital Disorders / Genitourinary</p> <input type="checkbox"/> Hernias <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Menstrual Disorder <input type="checkbox"/> Urinary Tract Infections <p>Infectious Diseases</p> <input type="checkbox"/> Chickenpox (Varicella) <input type="checkbox"/> Hepatitis A, B, C (Please circle) <input type="checkbox"/> HIV <input type="checkbox"/> Sexually Transmitted Infection <p>Mental Health</p> <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Attention Deficit (ADD/ADHD) <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Mental Health Treatment <input type="checkbox"/> Seasonal Affective Disorder	<p>Musculoskeletal</p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Scoliosis <input type="checkbox"/> Skeletal Disorder <p>Neurological</p> <input type="checkbox"/> Congenital/Spinal Cord Injury <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Seizures <p>Skin</p> <input type="checkbox"/> Acne <input type="checkbox"/> Eczema <input type="checkbox"/> Melanoma <input type="checkbox"/> Psoriasis <input type="checkbox"/> Urticaria (hives) <p>Endocrine</p> <input type="checkbox"/> <i>Diabetes Mellitus</i> <input type="checkbox"/> Lupus <input type="checkbox"/> Thyroid Disorder
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Do you have an illness or condition, not listed above, for which you are now being treated? If yes, specify.

List date(s) and reason(s) for any hospitalizations/surgeries.

Social Habits:

Do you use recreational drugs? Yes No Alcohol usage? Yes No # times per week _____ Amount per session _____
 Do you use tobacco? Yes No Do you exercise? Yes No # times per week _____

Family Health History *Has any family member had any of the following? Indicate F=father, M=mother, B=brother, S=sister*

Asthma	Cancer	Heart Disease	Migraine	Other (specify)
Arthritis	Diabetes Mellitus	Hypertension	Seizure Disorder	Other (specify)
Alcohol/Drug Abuse	Emotional Illness	Kidney Disease	Stomach Disorder	Other (specify)

Person to Notify in Case of Emergency

Name	Relationship	Preferred Phone ()
Address		Alternate Phone ()

Student Signature _____ **Date** _____