Admission Health Record Packet
Certificate of Immunity

Mail to: SAIC Health Services
37 S. Wabash Ave.
Chicago, IL 60603

Name (Print)_____Date of Birth _____/_____/_____
Last First MI Month Day Year

Home Phone Number(____)_____ SAIC Email Address _____ SAIC Student ID# _____

I authorize the School of the Art Institute of Chicago to release this immunization record to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Student's Signature _____*Date* _____

IMPORTANT! A non-refundable ***$100*** *fine will be placed on your account every semester if your immunization records are not complete and on file with the Health Services office.*

PLEASE NOTE! This certificate must be signed by a physician/healthcare provider to be valid under Illinois law. Information submitted below and all attached reports must be in English, or include a certified translation into English.

THE FOLLOWING ARE REQUIRED IMMUNIZATIONS

TETANUS/DIPHTHERIA: International students complete Section 1; US citizens or permanent residents complete Section 2.

SECTION 1: International Students	Identify immunization given:
a. 1st immunization	DATE MM/DD/YY a. / / Td or Tdap
b. 2nd immunization	b. / / Td or Tdap
c. 3rd immunization: tetanus/diphtheria booster. **(Given within the past 10 years)**	c. / / Td or Tdap

SECTION 2: U.S. Citizens or permanent residents	
Date of most recent tetanus/ diphtheria booster. **(Given within the past 10 years)**	Date of immunization / / **Identify immunization given:** Td **OR** Tdap

MMR (MEASLES/MUMPS/RUBELLA): All students must complete Section 3 OR 4. **Not required if born before 1957.*

SECTION 3: MMR*	MM/DD/YY
a. 1st immunization	a. / /
b. 2nd immunization	b. / /

SECTION 4	1st immunization	2nd immunization	Illness	Date of Poitive Lab/Serologic Evidence MUST include lab report
	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Measles*	/ /	/ /	/ /	/ /
Mumps*	/ /		/ /	/ /
Rubella*	/ /			/ /

THE FOLLOWING IMMUNIZATIONS ARE RECOMMENDED (NOT REQUIRED) FOR ALL STUDENTS

SECTION 5	1ST Immunization MM/DD/YY	2ND Immunization MM/DD/YY	3RD Immunization MM/DD/YY	Illness MM/DD/YY
Varicella (chickenpox)	/ /	/ /	/ /	/ /
Hepatitis B	/ /	/ /	/ /	
Meningococcal Meningitis	☐ Menomune ☐ Menactra / /			

NAME AND SIGNATURE OF HEALTHCARE PROVIDER VERIFYING ABOVE INFORMATION

Provider's Printed Name _____Stamp:

Signature _____Date _____

Address_____Phone Number(____)_____

Please do not write below the line, for office use only

FOR OFFICE USE

Date Received _____ Date Reviewed / Entered _____ Reviewed / Entered by_____ Complete ○ Incomplete ○

Missing _____ Action_____ Notes: _____