Certificate of Immunity – To be signed by healthcare provider

Name (Print) ____ Date of Birth ______/_____/_____
Last First MI Month Day Year

Home Phone Number (____)_________________ 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_____________________________

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:

DIPHTHERIA, TETANUS, PERTUSSIS

SECTION 1: Required for all students	Identify date and type of immunization given:	
	MM / DD / YY	Circle one:
a. 1st immunization	a. / /	DTP/DTaP /DT/Td/ Tdap
b. 2nd immunization (must be at least 4 weeks after 1st immunization)	b. / /	DTP/DTaP /DT/Td/ Tdap
c. 3rd immunization (must be at least 6 months after 2nd immunization): **Last dose must have been received within the past 10 years.**	c. / /	Td/Tdap
	One dose must be Tdap.	

MENINGOCOCCAL CONJUGATE VACCINE

SECTION 2: Required for students under 22 years of age; recommended for all students	
Meningococcal conjugate vaccine on or after 16 years of age Circle one: Menactra Menveo	Date of immunization: MM/DD/YY / /

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. / /

Both doses must be given on or after the first birthday. Second dose must be given at least 4 weeks after first dose.

SECTION 4:	1st immunization	2nd immunization	Date of Positive Titer (Lab Results) MUST include lab report
	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
Hepatitis B	/ /	/ /	/ /
HPV (Gardasil, Gardasil-9)	/ /	/ /	/ /
Meningitis B (Bexsero – 2 doses or Trumenba – 2 or 3 doses)	/ /	/ /	/ /
Varicella (Chickenpox)	/ /	/ /	
COVID-19 Product name/manufacturer: ______________________________	/ /	/ /	

NAME AND SIGNATURE OF HEALTHCARE PROVIDER VERIFYING ABOVE INFORMATION

Healthcare Provider's Printed Name____Stamp:

Signature____Date__________________________

Address____Phone Number (_______) ___________________