

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		MENINGOCOCCAL CONJUGATE VACCINE	
SECTION 1: Required for all students	Identify date and type of immunization given:	SECTION 2: Required for students under 22 years of age; recommended for all students	
a. 1 st immunization	MM / DD / YY Circle one: a. / / DTP/DTaP /DT/Td/ Tdap	One dose given at age 16 years of age or older.	Date of immunization: MM/DD/YY / / Specify brand (circle one): Menactra or Menveo
b. 2 nd immunization (must be at least 4 weeks after 1st immunization)	b. / / DTP/DTaP /DT/Td/ Tdap		
c. 3 rd immunization (must be at least 6 months after 2 nd immunization): Last dose must have been received within the past 10 years.	c. / / Td/Tdap *One dose must be Tdap.*		

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

SECTION 3: MMR*	MM/DD/YY	SECTION 4:	1 st immunization	2 nd immunization	Date of Positive Titer (Lab Results) MUST include lab report
a. 1 st immunization	a. / /	Measles* Mumps* Rubella*	MM/DD/YY	MM/DD/YY	MM/DD/YY
b. 2 nd immunization	b. / /		/ /	/ /	/ /
First dose must be given on or after the first birthday. Second dose must be given at least 4 weeks after the first dose.			/ /	/ /	/ /
			/ /	/ /	/ /

SECTION 5: COVID-19	1 st immunization MM/DD/YY	2 nd immunization (if 2-dose series) MM/DD/YY	3 rd immunization (booster) MM/DD/YY
Product name/manufacturer: _____	/ /	/ /	/ /

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

SECTION 6:	1 ST Immunization MM/DD/YY	2 ND Immunization MM/DD/YY	3 RD Immunization MM/DD/YY
Hepatitis B	/ /	/ /	/ /
HPV (Gardasil, Gardasil-9)	/ /	/ /	/ /
Meningitis B (Bexsero – 2 doses or Trumenba – 2 or 3 doses)	/ /	/ /	/ /
Varicella (Chickenpox)	/ /	/ /	

NAME AND SIGNATURE OF HEALTHCARE PROVIDER VERIFYING ABOVE INFORMATION

Healthcare Provider's Printed Name _____ Stamp: _____

Signature _____ Date _____

Address _____ Phone Number (____) _____