Certificate of Immunity – To be signed by healthcare provider

Student's 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	
	MM / DD / YY Circle one:	One dose given at age 16 years of age or older.	Date of immunization: MM/DD/YY / /
a. 1st immunization	a. / / DTP/DTaP /DT/Td/ Tdap		Specify brand (circle one): **Menactra** or **Menveo**
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.		

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. / /
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 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 6:	1st Immunization MM/DD/YY	2nd Immunization MM/DD/YY	3rd Immunization MM/DD/YY	4th Immunization MM/DD/YY	5th Immunization MM/DD/YY
COVID-19 (Include product name/manufacturer for each dose; designate bivalent if received)	/ / _____	/ / _____	/ / _____	/ / _____	/ / _____
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 (_____) _____