Northwestern University Office of the Registrar
Health Information Management Services Department

STUDENT IMMUNIZATION FORM

PHYSICIAN ASSISTANT

Important Notes – Please read prior to completing this form.

1. Provide proof of immunization by submitting **ONE** of the following:
   - REQUIRED IMMUNIZATIONS section on page 2 completed by a healthcare professional with required lab reports attached for **Measles**, **Mumps**, **Rubella**, **Hepatitis B surface antibodies**, **Varicella** and **QuantiFERON TB Gold blood test** and if required, **Chest X-ray report**. This page must be signed and dated by the healthcare professional to be valid, ***OR***
   - Submit a copy of your immunization record from your physician, former high school or university or other official immunization record, such as immigration paperwork, which lists all required immunizations, in addition to required **lab reports** for **Measles**, **Mumps**, **Rubella**, **Hepatitis B surface antibodies**, **Varicella** and **QuantiFERON TB Gold blood test**, and if required, **Chest X-ray report.**
2. Despite vaccination, it is not uncommon for a titer to be negative. If your first titer for any of the diseases is negative, you will need to complete an additional vaccination and repeat the titer 4-6 weeks later. Submit the form and all supporting documents, including the negative lab report/s and proof of any additional vaccination/s **by the May 1 deadline**. You will then be granted an extension to complete the repeat titer/s when due and without penalty.
3. **DEADLINE:** This form and proof of immunizations, including laboratory reports, should be submitted to Health Information Management Services at the Evanston Student Health Service **by May 1** to allow for any follow-up for any deficiencies.
4. **Submit documentation** – Preferred method: **submit your documentation online** by going to the Evanston Student Health Service website at https://www.northwestern.edu/healthservice-evanston/index.html. Click on the Personal Health Portal (PNC) link and enter your net ID and password which you also use for CAESAR. You will then need to enter your 7-digit student ID number (***no letters***) from your Wildcard or CAESAR. Select "immunization Upload" from the list on the left side of the page to upload your documentation. If you are not able to upload your record, you may **E-MAIL** to hims@northwestern.edu or **FAX** to: 847-491-8699. If you do not have access to a fax machine or a computer you may **MAIL** to: Health Information Management Services, 633 Emerson Street, Evanston, IL 60208.
5. **Confirmation:** Your @northwestern.edu email address will be used to communicate completion of immunization requirements or any immunization deficiencies once your records are processed by our team.
6. **Penalties** - Students who fail to submit the completed Student Immunization Form, including proof of immunizations, or fail to rectify deficiencies **within 30 days after the start of classes** will be both:
   - Assessed a non-refundable $100 late fee and
   - Barred from class registration for subsequent terms until compliant in accordance with Illinois State law.
7. **Questions** – For detailed information, visit the New Students tab on the Evanston campus Health Service website: https://www.northwestern.edu/healthservice-evanston/new-students/

Student Information (Please print or type.)

Last name _____ First name _____ Middle _____

Date of Birth (mm/dd/yyyy) _____ **Student ID Number** (*NO LETTERS*) _____ **Gender** (circle) Female Male Non-binary

Northwestern University Office of the Registrar HIMS department | 633 Emerson St • Evanston, IL • 60208 | Phone: 847-491-2117 | Fax: 847-491-8699
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Northwestern University

REQUIRED IMMUNIZATIONS FOR PHYSICIAN ASSISTANT STUDENTS

THIS PAGE MUST BE COMPLETED BY A HEALTHCARE PROVIDER (e.g. M.D., D.O., P.A. or Licensed Nurse), and include their name (printed), phone number, signature and date at the bottom, to be considered valid under Illinois State Law. **Lab reports for Measles, Mumps, Rubella, Hepatitis B, Varicella and the QuantiFERON TB Gold blood test must also be included**. All records must be in English.

Student Name: _____ **Student ID:** _____**Date of Birth:**_____

MEASLES (Rubeola), MUMPS, RUBELLA – Positive quantitative lab reports confirming immunity must be submitted to meet this requirement. May provide vaccination dates if known.

MEASLES Date #1: ____/____/_____ Date #2: ____/____/_____

MUMPS Date #1: ____/____/_____ Date #2: ____/____/_____

RUBELLA Date #1: ____/____/_____ Date #2: ____/____/_____

TETANUS/DIPHTHERIA/PERTUSSIS (Tdap)

- Must be within **10 years** prior to entrance into University.

Date: ____/____/_____

TETANUS/DIPHTHERIA SERIES – **Td, DT, DTP, DTaP or Tdap meet the requirement.**

- **MUST** list 2 dates from primary series (usually done in childhood) or previous booster dates, excluding the date listed above.
- Doses **MUST** be at least 28 days apart.

Date: ____/____/_____

Date: ____/____/_____

TUBERCULOSIS TESTING: Complete **ONE** of the following:

- **QuantiFERON® TB Gold blood test:** Must be completed in the USA on or after April 1st of the year you enter the program. A copy of the lab report must be submitted. If the QuantiFERON® TB Gold blood test result is positive, a chest x-ray must also be completed and attached to the result; you will also be required to meet with a Health Service physician after you are on campus.

OR

- **History of positive Tuberculosis test:** Submit Chest X-ray performed in the USA on or after April 1st of the year you enter the program. If available, also include historical positive Tuberculosis test result and if applicable, treatment records.

STUDENTS ARRIVING FROM OTHER COUNTRIES in need of a TB test and/or Chest X-Ray have until 30 days after the start of classes to complete without incurring penalty. **TB Tests and x-rays from other countries will not be accepted and <u>will be repeated at the student's expense</u>.** Please call the Chicago Campus Health Service at 312-695-8134 to schedule an appointment after arriving on campus.

HEPATITIS B TITER (Surface Antibodies) – **A positive lab report confirming immunity must be submitted to meet this requirement.** May list vaccination dates if known**.** If your titer did not prove immunity (negative or equivocal) or you just started the vaccination series, list dates of all vaccinations completed to date.

Date #1: ____/____/_____ **Date #2:** ____/____/_____ **Date #3:** ____/____/_____

VARICELLA (Chicken Pox) TITER - A positive quantitative lab report confirming immunity must be submitted to meet this requirement. May list dates of vaccinations or date of illness if known.

#1: ____/____/_____ **Date #2**: ____/____/_____ **Date of illness:** ____/____/_____

COVID-19 Vaccinations • MUST list at least 2 dates from primary series (submit documentation if you have more than 4 doses)

Date #1: ____/____/_____ Vaccine Name : _____ Date #3: ____/____/_____ Vaccine Name : _____

Date #2: ____/____/_____ Vaccine Name : _____ Date #4: ____/____/_____ Vaccine Name : _____

Healthcare Provider: By signing below, you attest that all information supplied in this section is true and correct to the best of your knowledge.

Name and title of Provider (printed): _____

Signature of Provider: _____ **Date:** ____/____/_____

Phone Number: (_____)_____

Address:

PART IV: STUDENT SIGNATURE (REQUIRED)

Please sign and date below. By signing you are certifying that all information supplied is correct to the best of your knowledge.

_____

Signature Date

PART V: TREATMENT/SHARING OF MEDICAL INFORMATION OF MINORS (UNDER AGE 18 YEARS)

As the parent/guardian of my minor (under 18 years of age) son or daughter, I hereby authorize:

1) The sharing/exchange of relevant medical information between Northwestern University representatives (officials, faculty, staff), Northwestern University Student Health Service, and, for the purpose of diagnosis and/or treatment, other medical providers. Each of the above individuals or entities is also authorized to communicate and discuss health matters with the parents/guardians/ emergency contacts of my minor child.
2) The transportation of my minor child, under appropriate circumstances, to area hospitals for diagnosis and treatment.
3) The provision, by the Northwestern University Student Health Service, of such diagnostic, therapeutic, voluntary immunization, and operative procedures as may be deemed necessary for my minor child.

Any and all related expenses will be the responsibility of the student and/or parent/guardian.

Student's Signature: _____ Date: _____

Signature of parent/guardian: _____ Relationship: _____ Date: _____

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