AURORA UNIVERSITY

Health Services
630-844-5434
630-844-5611 (fax)

HEALTH and IMMUNIZATION REQUIREMENTS

In accordance with the State of Illinois College Immunization Code (77 IL.ADM.CODE 694), all undergraduate students enrolled in 6 or more credit hours of on-campus instruction, and graduate/doctoral students enrolled in 4.5 or more credit hours of on-campus instruction must provide required immunization documentation as outlined below by the following deadlines:

FALL: Undergraduates by **July 15**; Graduate/Doctoral students prior to the first day of class

SPRING: Undergraduates by **December 1**; Graduate/Doctoral students prior to the first day of class

---

A. WHO IS MANDATED TO MEET THIS REQUIREMENT?

- All undergraduate, graduate and doctoral students meeting the above stated credit hour criteria
- All international students* and residential students must comply regardless of total credit hours and/or class locations

B. REQUIRED IMMUNIZATIONS:

- **Measles:** Two doses: First dose must be on or after first birthday. Doses must be at least 28 days apart. Titers showing immunity are acceptable.
- **Mumps**: Two doses: First dose must be on or after first birthday. Doses must be at least 28 days apart. Titers showing immunity are acceptable.
- **Rubella**: Two doses: First dose must be on or after first birthday. Doses must be at least 28 days apart. Titers showing immunity are acceptable.
- **Tetanus, Diphtheria, Pertussis:** Three doses of any combination (DPT, DTaP, Tdap); one dose must be Tdap; last dose of vaccine must be dated within the past 10 years.
- **Meningitis (Meningococcal Conjugate):** One dose on or after 16th birthday for all students less than 22 years old. *[Please note: Serogroup B meningococcal vaccine is optional and does not satisfy requirement.]*

***Special Note for International Students**: In addition to the above, all international students are to submit Tuberculosis Screening prior to arrival to campus. Positive screen results require tuberculosis testing (PPD, Mantoux or IGRA-lab test) within six months prior to enrollment at AU and annually thereafter. Results of tuberculosis skin test must be interpreted and recoded by your physician in English on the AU immunization form. Chest x-rays are required for all positive tests. Please include a copy of the chest x-ray report.*

C. ACCEPTABLE FORMS OF DOCUMENTATION:

- Complete and signed Student Health/Immunization Record by your healthcare provider.
- All records must be in English, clearly legible, and include name and date of birth.
- You may attach comparable immunization documentation to the Student Health/Immunization Record in lieu of completing immunization section of the form. Examples of acceptable documentation may include but not limited to the following:
  - Immunization records from a prior educational institution (high school, college/university) as long as records have school letterhead clearly visible.
  - Military records documenting the month, day and year of immunization administration.
- For Measles, Mumps and Rubella requirement only, you may submit antibody titer lab report (blood test) indicating positive immunity. Please note values in the "equivocal" range are not considered to indicate positive immunity.
- Please be aware that receipt showing payment for vaccine is not acceptable. Documentation must clearly indicate the vaccine was administered.

CI. HOW TO SUBMIT RECORDS TO HEALTH SERVICES:

- **SpartanHealth Portal:** Upload immunization records through the student health portal. Please visit aurora.studenthealthportal.com and use your AU email and password to access the portal.
- **Fax:** 630-844-5611
- **Mail:** 347 S. Gladstone Ave., Aurora, IL 60506 (Attention: Health Services)
- **In-person:** 1317 Marseillaise Place (across street from the library).

*Please note: If shot records are required by another AU department (e.g. Athletics, Nursing), it is your responsibility to submit a separate copy to each department***.**

CII. QUALIFICATIONS FOR "IMMUNIZATION EXEMPTION STATUS":

- Students may submit request for Medical or Religious Exemption to this requirement. Please go to "Health and Immunization Records" at aurora.edu/wellness for additional information.
- Students born before 1/1/1957 are exempt from the Measles, Mumps, and Rubella requirement; however, Tetanus, Diphtheria, Pertussis are still required.

CIII. WHAT HAPPENS IF IMMUNIZATION RECORDS ARE NOT SUBMITTED?

- Failure to provide Health Services with required immunization records will result in having an immunization hold placed on your student account that prevents future registration or adjustment of your schedule until all required records have been received.

CIV. QUESTIONS? CONTACT US!

- AU Health Services 630-844-5434
- Please go to "Health and Immunization Records" at aurora.edu/wellness for additional information.

Health Services
Phone: 630.844.5434
Fax: 630.844.5611

Immunization Record

Student Name: ______________________ Student ID#: ______________

Date of Birth: _____ /_____/_____

I. Measles, Mumps, and Rubella Requirement:

MMR (Measles, Mumps, Rubella) Vaccine*
Two doses required. First dose must be given on or after 1st birthday, and doses must be given at least one month apart.

#1 _____ /_____/_____ (Month Day Year) #2 _____ /_____/_____ (Month Day Year)

*If MMR was not given, individual immunization or antibody titers should be listed below

Measles (Rubeola, Hard, Red, 10 day)

Two doses required, at least one month apart, and after 12 months of age and after 1/1/68, or

#1 _______ /_______/_______ (Month Day Year) #2 _______ /_______/_______ (Month Day Year)

Antibody titer test (blood test) proving immunity *

_______ /_______/_______ (Month Day Year) **Attach lab report (required)**

Rubella (German Measles, 3 day)

Two doses required after 12 months of age and after 6/19/69, or

#1 _______ /_______/_______ (Month Day Year) #2 _______ /_______/_______ (Month Day Year)

Antibody titer test (blood test) proving immunity *

_______ /_______/_______ (Month Day Year) **Attach lab report (required)**

Mumps

Two doses required after 12 months of age and after 1/1/68, or

#1 _______ /_______/_______ (Month Day Year) #2 _______ /_______/_______ (Month Day Year)

Antibody titer test (blood test) proving immunity *

_______ /_______/_______ (Month Day Year) **Attach lab report (required)**

**All antibody titer results within "equivocal" range will require further written clarification by your physician*

II. Tetanus-Diphtheria-Pertussis (DTP, DTaP, Td, Tdap) Requirement:

Three doses of any combination (DTP, DTap, Td, Tdap) required. One dose must be a Tdap vaccine, and the last dose (Tdap or Td) must be given within the past 10 years. Please circle the appropriate vaccine.

Please indicate: DTP / DTaP / Tdap / Td DTP / DTaP / Tdap / Td Last Dose: Tdap or Td

#1 _____/_____/_____ (Month Day Year), #2 _____/_____/_____ (Month Day Year), #3 _____/_____/_____ (Month Day Year),

III. Meningococcal Vaccine Requirement:

Students under the age of 22 must submit documentation of at least one dose of a meningococcal conjugate vaccine given on or after their 16th birthday.

#1 Meningococcal Conjugate #2 Meningococcal Conjugate Meningococcal Serogroup B (Recommended, not Required)

_____/_____/_____ (Month Day Year), _____/_____/_____ (Month Day Year) _____/_____/_____ (Month Day Year), _____/_____/_____ (Month Day Year), _____/_____/_____ (Month Day Year)

V. Recommended Immunizations: (the following immunizations are highly recommended, but not required unless specified by your major)

Hepatitis B #1 _____/_____/_____ (Month Day Year), #2 _____/_____/_____ (Month Day Year), #3 _____/_____/_____ (Month Day Year)

COVID-19 #1 _____/_____/_____ (Month Day Year), #2 _____/_____/_____ (Month Day Year), #3 _____/_____/_____ (Month Day Year)

Influenza-highly recommended that all college students get a flu shot annually

_____/_____/_____ (Month Day Year)

VI. Healthcare Provider Verification of Immunization Record (**Required**)

Name: ______________________ Phone: ______________

Address: ______________________

Signature: ______________________ Date: ______________

Office Stamp:

International students are required to submit an annual TB Screening Form through their SpartanHealth Portal. Please contact Health Services for any questions or concerns.

Health Services
630.844.5434
630.844.5611 (fax)
shs@aurora.edu

CONFIDENTIAL
Student Health Record
Please print

Sex: ☐ Male ☐ Female

Name: ______________________________ (Last / First / Middle) Date of birth: ___/___/____ (MM DD YYYY) Student ID: ______________

Permanent Address: ______________________________ (Street / Apartment number) ______________ (City / State /Zip) Country: ______________

Do you plan to live on campus? ☐ Yes ☐ No Cell phone number: ______________

Parent/Guardian: ______________ (name) ______________ (relationship) ______________ (home phone) ______________ (work phone)

______________ (name) ______________ (relationship) ______________ (home phone) ______________ (work phone)

In case of emergency, notify: ______________ (name) ______________ (phone number)

Primary Care Physician: ______________ (name) ______________ (address) ______________ (phone number)

Semester/Year of enrollment: Fall_____ Spring_____ Summer_____ Will you be attending: ☐ Full Time ☐ Part Time

Class Standing: ☐ FR ☐ SO ☐ JR ☐ SR ☐ Grad ☐ Other:__________ Have you previously attended AU?: ☐ No ☐ Yes ________ (when?)

Personal History: Please comment on all "yes" answers in the space below or on an additional sheet if you have or have had in the past.

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Anemia			Counseling/Mental Health Treatment			Headache (recurrent			Strep Throat (recurrent)		
Anxiety/Panic Attacks			Diabetes (Type I or II)			Heart Condition/Murmur			Substance Abuse		
Asthma (Chronic)			Digestive Tract Problems			High Blood Pressure			Thyroid Problem		
Asthma (excercise induced)			Disability			Kidney/Urinary tract Problem			Tuberculosis		
Autoimmune			Dizziness/Fainting			Mononucleosis			Vision/Hearing Loss		
Bleeding/Blood disorders			Eating Disorder			Respiratory Problems			Other (please explain below)		
Cancer/Tumor/Cyst			Head Injury (With unconsciousness)			Seasonal Allergies					
Chicken Pox						Seizure Disorder					

____

____

Do you have any allergies? (medications, foods, environmental, animals-including insects) ☐ No ☐ Yes (explain below)

Allergen/Reaction	

Are you currently taking any medications? (Please include medications taken on a regular basis, or as needed along with any vitamins, herbal or nutritional supplements) ☐ No ☐ Yes (explain below)

Medication (name, dose, frequency and reason)*	

*if you administer prescribed injectable medications, contact the Wellness Center to receive information on proper disposal of syringes and needles.

Have you ever been hospitalized or had any surgical procedures? ☐ No ☐ Yes (explain below)

Reason/Dates	

Have you previously received academic accommodations (IEP or 504 plan)? ☐ No ☐ Yes

Do you have a family history of the following?

Disease	No	Yes	Relation	Disease	No	Yes	Relation	Disease	No	Yes	Relation	Disease	No	Yes	Relation
Anxiety/Panic Attacks				Depression				Heart Disease				Stroke			
Bipolar Disorder				Diabetes				Hypertension				Sudden death before age of 50			
Cancer				Drug/Alcohol Dependence				Schizophrenia				Tuberculosis			

I hereby certify that the above questions have been answered to the best of my knowledge.

____

student signature This information is strictly for Health Services/Counseling Services/Disability Services and will not be released to anyone without your written consent. date