AURORA UNIVERSITY
Wellness Center
347 S. Gladstone Ave., Aurora, IL 60506-4892

Health Record Requirements: Rules for Completion and Compliance

Welcome to Aurora University. As part of your preparation for joining the AU community, specific health/immunization records need to be on file in the Wellness Center. The State of Illinois College/University Immunization Law (77 ILL. ADM. CODE 694) requires that the following students born on or after 1/1/57 provide proof of immunity to Measles, Mumps, Rubella and Tetanus/Diphtheria:

A. **All residential students (students who will be living in on-campus housing)**

B. **All undergraduate and graduate students enrolled in 9 or more credit hours per 16 week semester (or equivalent) and whose class sessions meet on the Aurora University campus**

C. **All international students, in addition to the above, are required to provide dates of any combination of 3 or more doses of Diphtheria, Tetanus, and Pertussis (DTP), Diphtheria and Tetanus (DT) or Tetanus and Diphtheria (TD) vaccine with the most recent dose having been received within 10 years of the term of current enrollment.**

   In addition a tuberculosis (TB) test (PPD/Mantoux or IGRA) is required within 6 months prior to enrollment and then annually thereafter. Results of TB test must be interpreted and recorded by your physician on our Certificate of Health Examination and Immunity form. A chest x-ray will NOT be accepted as a substitute for a test. However, a chest x-ray is required if either test is positive (please include report). The tuberculin requirement applies regardless of BCG vaccination.

For all **undergraduate** students who meet the above stated criteria, health/immunization records must be submitted to the Wellness Center prior to July 15 for Fall semester enrollment, December 1 for Spring semester enrollment, and before participation in intercollegiate athletics.

For all **graduate and adult degree completion students** who meet the above stated criteria, health/immunization records must be submitted to the Wellness Center before the first day of class.

Enclosed you will find a 4-page "Certificate of Health Examination and Immunity" form. It is important that all information is thoroughly completed. Below are detailed completion instructions.

"Certificate of Health Examination and Immunity" form Completion Instructions		
PAGE 1:	Health History Section	Required for all the above listed students (sections A, B, and C)
PAGE 2:	Health History Section	Required for all the above listed students (sections A, B, and C)
PAGE 3:	Physical Examination Section	Required for all students who will be living in a residence hall and/or participating in intercollegiate athletics ***(see note below)**
PAGE 4:	Immunization History Section	Required for all the above listed students (sections A, B, and C)

PAGE 3 and PAGE 4 must be complete and signed by a physician (and/or equivalent)

**** All students living in a residence hall need to have a current physical on file in the Wellness Center prior to occupancy in the residence hall. A current physical is defined as a physical signed by a physician and/or equivalent, and dated within one year prior to starting your first semester at AU. (All students participating in intercollegiate athletics must have a physical on file prior to any athletics participation and it must be dated within six months of initial participation. Please visit http://www.aurora.edu/athletics/forms.htm for more information.)***

Proof of immunity to Measles, Mumps, Rubella and Tetanus/Diphtheria can be met by the following:

- Have your private health care physician complete and sign Page 4 of the "Certificate of Health Examination and Immunity" form
- Attach a copy of your high school immunization records
- Attach comparable documentation from prior college or university attended
- Attach a copy of military records that show proof of required immunizations

(Immunization records must be in English and the month, day and year for each administered vaccine must be clearly visible)

Important Notice:
Students who do not provide the Wellness Center with the immunization documentation required by the State of Illinois College/University Immunization Law will have an immunization hold placed on their student account and will not be allowed to register for the next semester.

Immunization Exemptions:
Anyone with an immunization exemption may be excluded from the university in the event of Measles, Mumps, Rubella or Diphtheria outbreak in accordance with Illinois Department of Public Health recommendations. Students will be granted an exemption to the immunization requirement for the following reasons:

- **Born before 1/1/57**

- **Class sessions meet at a location other than the Aurora University campus**

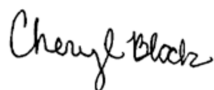
- **Religious Exemption**
  You may be exempt from one or more of the specific immunization requirements by submitting a written statement dated and signed by you or parent/guardian if less than 18 years of age, describing your objection to immunizations based upon bona-fide religious tenets or practices.

- **Medical Reason**
  You may be exempt from one or more of the specific immunization requirements by submitting a written statement from your primary physician indicating the nature and duration of the medical condition (including pregnancy) that contraindicates such immunizations and identifies the specific vaccine(s) that is (are) detrimental to your health. Statement must be signed and dated by your physician. For your convenience you can print an "Immunization Exemption: Medical Reason" form at aurora.edu/wellness/forms/exemption.pdf.

- **Credit Hours**
  All students enrolled in less than 9 credit hours per 16 week semester (or equivalent).

For those students who are in need of the required immunizations, the Wellness Center can provide information regarding where immunizations can be obtained. Please phone (630) 844-5434 or e-mail cblock@aurora.edu with any questions. You can also visit the Wellness Center Web site at www.aurora.edu/wellness for further information and a list of commonly asked questions.

On behalf of the Wellness Center staff, welcome to Aurora University.



Cheryl Block, R.N., M.S.
Director, Wellness Center
Phone: 630-844-5434
Fax: 630-844-5611

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Certificate of Health Examination and Immunity

Please see attached Rules for Completion and Compliance page for submission deadlines.

Name:___________________________________ **Date of Birth:**____/____/____ **Sex:** ❒ M ❒ F **SS#:**_________________
(Last / First / Middle) Month / Day / Year

Permanent Address:____ **Phone Number:**____________________
(Street/Apartment Number)
____ **Country:**_________________________
(City / State / ZIP)

Do you plan to live on campus? ❒ Yes ❒ No **Campus Phone Number:**__________________

Parent/Guardian:___________________________ _______________ __________________ ____________________________
(Name) (Relationship) (Home Phone) (Work Phone)
___________________________ _______________ __________________ ____________________________
(Name) (Relationship) (Home Phone) (Work Phone)

In case of emergency, notify:____

Semester and year of enrollment: ❒ Fall____ ❒ Spring ____ ❒ Summer ____
Class Standing: FR / SO / JR / SR / 5th / Graduate Student _____ (year) **Will you be attending:** ❒ Full-time ❒ Part-time

Have you previously attended Aurora University? ❒ No ❒ Yes - If yes, please indicate year(s)____________

Are you an AU athlete? ❒ No ❒ Yes – If yes, **please indicate which sport(s):** ____

Have you had: *

	NO	YES		NO	YES		NO	YES
Allergies (seasonal)			Respiratory problems			Rheumatic fever		
Head injury			Tuberculosis			High blood pressure		
Dizziness/fainting			Gastrointestinal problems			Low blood pressure		
Dizziness/fainting with exertion			Loss of paired organ function			Heat related illness (exhaustion/stroke)		
Headaches (migraines)			Recent weight changes			Hernia		
Seizure disorder			Gallbladder problems			Kidney/urinary problems		
Meningitis			Stomach ulcers			Anemia		
Ear problems (hearing loss)			Diabetes Mellitus (Type I/II)			Blood disorders		
Eye problems			Low blood sugar			Cancer		
Sinus problems			Liver disease			Chicken pox		
Strep throat (recurrent)			Hepatitis A, B, C			Fracture/sprain		
Thyroid problems			Mononucleosis			Back problems		
Frequent colds			Heart murmur			Marfan's Syndrome		
Asthma (chronic)			Heart arrhythmia			Eating disorders		
Asthma (exercise induced)			Heart disease			Counseling/mental health treatment		

Orthopedic Injuries: *

	NO	YES		NO	YES
Ankle		R L	Elbow/arm		R L
Shin Splints		R L	Wrist/hand		R L
Knee		R L	Neck		R L
Hip		R L	Head		
Back			Concussion/loss of consciousness		
Shoulder		R L	Internal		

Please explain all answers marked with *YES:
____
____

I HEREBY CERTIFY THAT THE ABOVE QUESTIONS ARE ANSWERED TO THE BEST OF MY KNOWLEDGE.

Student Signature:____ Date:__________________

Health History: Please answer all of the following questions.

1. **Do you have any allergies? *(medications, foods, environmental, insect bites/stings):*** ❒ No ❒ Yes (explain below)

Allergen	Reaction

2. **Are you currently under the supervision of a physician?** ❒ No ❒ Yes (please explain below)
   If yes, please explain:____

3. **Are you currently taking any medications?** ❒ No ❒ Yes (please list below)
   Please include medications taken on a regular or as-needed basis along with any vitamins, herbal or nutritional supplements.

Medication (name, dose, frequency)*	Reason
**If you administer injectable prescription medications, contact the Wellness Center to receive information on disposal of syringes and needles.*	

4. **Have you ever been hospitalized (injury or illness) or had any surgical procedures?** ❒ No ❒ Yes (please list below)

Reason	Dates

5. **Have you ever been diagnosed with a stress fracture?** ❒ No ❒ Yes (please provide details below)

Location	Date

6. **Do you have a family history of the following?**

Disease	No	Yes	If yes, please indicate relationship
Diabetes			
Cancer			
Heart disease			
Hypertension			
Tuberculosis			
Stroke			

****Has any member of your family died suddenly before the age of 40 from a non-traumatic cause?***
❒ No ❒ Yes - If yes, please explain how: ____________________________

7. **Please complete the appropriate section:**

For Women	For Men
Onset first menstrual period (age):	Testicular conditions ❒ No ❒ Yes **Explain:**
Abnormal flow? ❒ No ❒ Yes **Explain:**	
Excessive/severe cramping? ❒ No ❒ Yes	Prostate conditions ❒ No ❒ Yes **Explain:**
Pregnant now or within past year? ❒ No ❒ Yes	
Date of last pelvic exam**:**	

8. **Is there anything we should know about your health that we have not asked yet?** ❒ No ❒ Yes
   If yes, please explain:____

I HEREBY CERTIFY THAT THE ABOVE QUESTIONS ARE ANSWERED TO THE BEST OF MY KNOWLEDGE.

Student Signature:__________________________________ Date:________________

Physical Examination: To be completed by a physician

TO THE EXAMINING PHYSICIAN: Please review the student's history, complete the physical examination and immunization history and comment on all positive answers (also complete and sign page 4).

A physician signature is required for the physical examination and immunization history sections.

Student's Name: Date of Birth:

Required Measurements				Strongly Recommended Tests	
Height	**Weight**	**B/P**	**Pulse**	**Urinalysis (dipstick)** Alb.______ Sug.______	**Hemoglobin or Hematocrit** ______ gms/% ________%

Clinical Evaluation:	Normal	Abnormal	Comments
Skin			
Eyes, ears, nose, sinuses			
Mouth/dental			
Throat			
Heart (murmurs, size, sounds)			
Respiratory system			
Gastrointestinal system			
Genital-urinary system			
Neurological status			
Musculoskeletal system			
Spinal examination			
Nutritional status **Please list any dietary restrictions*			
Mental health			
Other *(general comments)*			

Orthopedic Exam: ❒Normal ❒ Abnormal
(Please explain all abnormalities or orthopedic concerns)

Recommendations for physical activity in physical education, intercollegiate, or club sports (select one):

❒ There are ***no restrictions*** for participation of the above named student in intercollegiate athletics, physical education or club sports.

❒ The above-named student ***may participate only after*** the following steps have been taken to ensure good health.
(Please explain): ____

❒ The above-named student ***may not participate*** in intercollegiate athletics, physical education or club sports.
(Please explain):____

Physician Verification of Physical Exam (Required):	**Office Stamp:**
Physician Name:______________________ Date of Exam:__________ Address:______________________________ Phone Number (with area code) :__________Signature:______________	

Student's Name:______________________________ **Date of Birth:**______________________

MMR (measles, mumps, rubella)*

Two doses required, at least one month apart, and
after 12 months of age and after live vaccine available (5-1-71) #1_____/_____/_____ #2_____/_____/_____
month / day / year month / day / year

***IF MMR WAS NOT GIVEN, INDIVIDUAL IMMUNIZATIONS SHOULD BE LISTED BELOW**

MEASLES (Rubeola, Hard, Red, 10 day)

❐ 1. Two doses required at least one month apart, after 12 months of age and after (1-1-68) #1_____/_____/_____ #2_____/_____/_____
month / day / year month / day / year

OR ❐ 2. Date disease diagnosed and certified by physician _____/_____/_____ **Attach letter from physician (MD or DO)**

OR ❐ 3. Lab test proving immunity _____/_____/_____ **Attach lab report**

RUBELLA (German measles, 3 day)

❐ 1. One dose required after 12 months of age and after (6-19-69) _____/_____/_____
month / day / year

OR ❐ 2. Lab test proving immunity _____/_____/_____ **Attach lab report**

MUMPS

❐ 1. One dose required after 12 months of age and after (1-1-68) _____/_____/_____
month / day / year

OR ❐ 2. Date disease diagnosed and certified by physician _____/_____/_____ **Attach letter from physician (MD or DO)**

OR ❐ 3. Lab test proving immunity _____/_____/_____ **Attach lab report**

DIPHTHERIA, PERTUSSIS, TETANUS, TETANUS/DIPHTHERIA

#1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____ #4_____/_____/_____
month / day / year month / day / year month / day / year month / day / year

Latest Booster:

_____/_____/_____
month / day / year

Please indicate: ❐ Td ❐ Tdap
(must be within past 10 years)

Recommended Immunizations

*** The following immunizations are highly recommended but not required unless specified by your major or citizenship status. ***

All international students are required to have a tuberculosis test within 6 months prior to enrollment and then annually thereafter.

Athletic Training and Nursing Majors require additional immunizations:

Nursing majors: Hepatitis B series, Two-Step Tuberculosis Skin Testing and Results, and proof of immunity to Varicella.

Athletic training majors: Hepatitis B series

HEPATITIS B (3 doses of vaccine):

1st: _____/_____/_____ **2nd:** _____/_____/_____ **3rd:** _____/_____/_____
month / day / year month / day / year month / day / year

INFLUENZA:

_____/_____/_____
month / day / year

Annual immunization recommended to avoid disruption to academic activities

VARICELLA (Requirements can be met by one of the following):

❐ Immunization **Dose #1 Date:** _____/_____/_____ **Dose #2 Date:** _____/_____/_____

OR ❐ History of Disease Yes / No **Date:** _____/_____/_____

OR ❐ Varicella antibody Reactive / nonreactive **Date:** _____/_____/_____

MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135):

If initial dose given at age 13-15 yrs: booster dose at 16-18 yrs. of age is recommended.

❐ **Conjugate (MCV4):** _____/_____/_____ **OR** ❐ **Polysaccharide (MPSV4):** _____/_____/_____
(Preferred) (Acceptable alternative if conjugate not available)

TUBERCULOSIS TEST (PPD/Mantoux or IGRA — please specify test):

Date Given: _____/_____/_____ **Date Read**: _____/_____/_____ **Results**: Negative / Positive - **If positive, Chest X-ray required;**
Date _____/_____/_____ **Chest X-ray results:** Normal / Abnormal

****Nursing Students Only****

PPD one-step given on _____/_____/_____, read on _____/_____/_____ **Results:** Negative / Positive **Signature:**______________

PPD two-step given on _____/_____/_____, read on _____/_____/_____ **Results:** Negative / Positive **Signature:**______________

Physician Verification of Immunization History (Required):

Physician Name:______________________ Phone number:______________________

Address:____

Signature:______________________________ Date:________________

Office Stamp:

For Office Use Only								
Complete:	**Reviewed by:**	**Date:**	**Entered into Computer:**	**Exemptions:**	Medical	Religious	Age	Allergy