Please Print or Type	Olivet Naza	rene University I	Health a	an	d l	lm	m	un	İZ	ati	or	١F	or	m				
Student's Name:	LAST	FIRST MIDI	ONU I.D. #	#					erm F ttend		Fall	□ {	3prin(	g 🗆	Year	r		
.ddress:	2.01	THO!					Birth	date:					Se	ex: M	ı 🗆	FΓ	1	
	STREET	CITY SS#:	STATE	+o C	ZIP					O. D	AY '	ΥR.					-	
elephone: ()	·	55#	ONU Intercollegia	ile S	JOILS.								_		_			_
PART I. MEDIC		PART II. IMMUNIZAT	•									,						
o be completed by Please check any of	the student. the following you have	Please provide the month, you cannot determine if the			-							-			h is	requ	iired	if
ad or now have:	the following you have	you cannot determine it in	e vaccine was	917		101 1	-		IIIII				uge.				_	
Acne	☐ Frequent	REQUIRED IMMUNIZATIONS		МО	<b>1</b> DAY	YR	МО	<b>2</b> DAY	YR	МО	3 DAY	YR	МО	<b>4</b> DAY	YR	МО	<b>5</b> DAY	YF
AIDS	sore throats	DPT (Diphtheria/Pertussis/Tetanus)																ī
Alcoholism	☐ Hearing loss	<b>DT, TD</b> (Diphtheria/Tetanus), <b>TDAP</b> (Tetanus/Diphtheria/Pertusis) <b>Booster</b>	or ADACEL													$\vdash$		T
Allergies	☐ Heart problems ☐ Hemorrhoids			_									<u> </u>	$\vdash$	<u> </u>	⊢		╄
Anemia Arthritis	☐ Hepatitis B	COMBINED MMR (Measles/Mumps/ required 28 days apart, beginning on or																
Asthma	☐ Hernia	COMBINED MR (Measles/Rubell	a)													П		Т
Back problems	☐ Hypertension	<u> </u>		$\vdash$									├					
Bladder infections	☐ Insomnia	RUBEOLA (disease date or titer of	RUBEOLA (disease date or titer date)										1	•	titer			
Bleeding disorder	☐ Jaundice	RUBELLA (titer date — disease d	RUBELLA (titer date — disease date not acceptable												flab			,
Bronchitis	☐ Joint pain	MUMPS (disease date or titer dat	te)											MUS	ı be	allac	neu.	,
Cancer Chest pain	☐ Kidney disease☐ Measles (German)															_		
Chicken pox	(Rubella)	RECOMMENDED IMMUNIZATION	ONS	MO	<b>1</b> DAY	YR	MO	<b>2</b> DAY	YR	МО	3 DAY	YR	MO	<b>4</b> DAY	YR	MO	<b>5</b> DAY	YF
Chronic cough	☐ Measles (Rubeola)	HEPATITIS A			T			T	Ι		T						Ī	Τ
Colds	☐ Mumps	HBV (Hepatitis B)														$\vdash$		$\vdash$
Concussion	☐ Mono	MENINGOCOCCAL (Meningitis)														П		Т
Crying spells	☐ Nervous exhaustion	POLIO Vaccine																
Depression	☐ Night sweats☐ Painful urination	VARICELLA (Chicken Pox) (or disea	ise date)															
Diabetes Dizziness	☐ Pneumonia	HPV (Gardasil)																
Drug addiction	Polio	TB Skin Test																
Earaches	☐ Rectal bleeding	HEALTH PROVIDER SIGNATU	RE (physician, R	N. PA	A. sch	nool ı	nurse	ors	choo	l hea	lth of	ficial)	verif	vina	immı	uniza	tions	s:
Eating disorder	☐ Rheumatic fever		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	,							,		,9				
Epilepsy	☐ Scarlet fever												DAT	ГЕ				
Eye problems Fainting	☐ Shortness of breath☐ TB																	
Frequent	□ Ulcers		SIGNATURE											DAT	ſΕ			
headaches	☐ Venereal disease	PART III. PHYSICAL	FXAMINAT	ON	(To	he co	mnlet	ed hv	nhvsi	cian	nurse	nract	itione	r or ni	hvsici	ian's a	ssist	ant)
Frequent	☐ Whooping cough	EVALUATION:			(10)	00 00		_									33131	1111)
indigestion		EVALUATION:	(Required within 12 months of enrollment)  AL ABNORMAL FOLLOW-UP — COMMENT															
			NORMAL	AE	SNOR	WAL			FOLI	_Ovv	-UP -	- 00	MINIE	NI				
rug Allergies		Height Weight	-	+												—		
		Heart Rate		+			$\vdash$					—	—		—	—		
		Blood Pressure Skin		+														
juries/Accidents		Eyes		+			$\vdash$											
,		Ears		1														_
		Nose																
		Throat																
Surgery (Operations)		Throat/Dental																
		Cardiovascular		_														
		Respiratory																
		Gastrointestinal		+														
ermanent disability (t	type)	Genito-Urinary																
		Muscular Skeletal																
		Scoliosis Screening																
outino modications (	liet)	Nutritional Status																
outine medications (	list)	Other																
		ON THE BASIS OF THIS EXAM	AINATION ON TH	HIS D	AY, I	APPI	ROVE	E THI	S ST	UDE	NT'S	PAR <sup>1</sup>	ГІСІР	ATIO'	N IN:			
		Interscholastic Sports (for 1																
		Physical Education												]	□ N(	Э		
		IF NO, PLEASE ATTAC	CH EXPLANATIO	V.														
STUDENT'S	S SIGNATURE	Physician's Name (Print)																
		Physician's Signature																
		Address																

## Immunization Rules—Please read carefully!

The Illinois College Student Immunization Act (110-ILCS 20) states: All students born on or after January 1, 1957, and ENROLLED IN 6 OR MORE HOURS OF ON-CAMPUS CLASSES must submit proof of immunity for diphtheria/tetanus, measles, mumps and rubella. Compliant immunization records for new students must be received by the office of Counseling & Health Services by August 1 for new students enrolling in the Fall Semester and December 15 for new students enrolling in the Spring Semester.

Students not in compliance with Illinois' immunization law 30 days after the first day of classes will receive a \$25 non-compliance charge to their student accounts. Students who remain in non-compliance will have a hold placed on their University records and will be unable to register for future semesters at Olivet Nazarene University.

## **HOW TO COMPLETE THIS FORM:**

- 1. Part I must be completed and signed by the student.
- 2. **PART II** <u>must be signed</u> by either your doctor, a registered nurse or other public health official and may be completed by attaching one of the following:
  - A. A copy of the student's health records from high school.
  - **B.** Comparable documentation from prior college or university.
  - **C.** Verification of immunization taken from your doctor's records, military records or other health care provider such as a Public Health Department.

## **SPECIFIC REQUIREMENTS:**

Td—Booster required within the last 10 years. TETANUS TOXOID IS NOT ACCEPTABLE.

MEASLES\* (Rubeola)—Must show proof of TWO doses after 12 months of age.

RUBELLA\* (German Measles)—One dose required after 12 months of age.

MUMPS\*—One dose required after 12 months of age.

\*Two doses of MMR vaccine eliminate the need for separate measles, mumps and rubella doses.

**International students** must submit proof of three DTs and two MMRs.

- 3. PART III must be completed and signed by your physician within 12 months prior to enrollment.
- 4. All dates must include MONTH, DAY and YEAR.
- 5. All laboratory evidence of immunity must be accompanied by a copy of the lab report.
- 6. History of disease is NOT acceptable as proof of immunity for RUBELLA.
- 7. All live vaccines must have been given after 1969, ON OR AFTER 12 MONTHS OF AGE.

**Incoming Intercollegiate Athletes:** Copies of your physical exam **must be sent to Counseling & Health Services** in addition to your coach or athletic office.

Please save a copy of your health forms for your records.

MAIL OR FAX HEALTH FORMS TO:

Counseling & Health Services
Olivet Nazarene University
One University Avenue, Box 6032
Bourbonnais, IL 60914

**FAX: PHONE:** 815-935-4997 815-939-5256