Lincoln College Immunization Form

300 Keokuk Street, Lincoln, IL 62656 Phone: (217) 735-7340 Fax: (217) 735-5214

Section A

||||||| **THIS IS NOT A PHYSICAL FORM** |||||||

Last Name First Name Initial Maiden

Street Address City State Zip Code

ID #: _____ Birthdate: _____/_____/_____ Gender:_____

Statement by the student: I authorize Lincoln College to release this immunization information to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Signature of Student: _____ Date: _____

Section B

This requirement may be met in one of these ways. Please indicate which way.

- ☐ 1. Have a physician complete this form.
- ☐ 2. Submit public school health records signed by a physician or nurse. Military records are also applicable.
- ☐ 3. Attach a copy of immunization records with a physician's signature or clinic stamp.

1. Required Immunization Information

Diptheria-Pertussis-Tetanus (DPT OR baby shots)	1	2	3	4	
Tetanus Diptheria (TD - within 10 yrs. of attendance, every 10 yrs as adult)	1	2			
MMR	1	2			
Measles (hard,red,10 day)	1	2	- or Measles titer - attach lab report		
Rubella (3 day, German) after 12 months and after 12/31/65	1	- or Mumps titer - attach lab report			
Mumps	1	- or Rubella titer - attach lab report			
Meningococcal Vaccine	1	2			

2. Recommended immunization information - not required for attendance at Lincoln College.

Hepatitis B	1	2	3
Hepatitis A	1	2	
ChickenPox	1	2	

Physician or Public Health Official Verification

I verify to the best of my knowledge that the above immunization information is correct.

Physician Name (print or stamp)_____ Signature_____ Date_____

Address_____ Phone_____

Revised 3/16 DLS