INSTRUCTIONS. PLEASE READ CAREFULLY:

1. All dates must include MONTH and YEAR.
2. PART II must be completed and signed by a health care provider(s). A health care provider is a physician licensed to practice medicine in all of its branches (M.D. or D.O.), a Licensed Nurse, or a Public Health Official.
3. A copy of laboratory report(s) in English must accompany laboratory evidence of immunity for Measles, Mumps, and/or Rubella. Translations of non-English documents must be certified.
4. History of disease is not acceptable as proof of immunity for Rubella.
5. Two (2) Measles (Rubeola) vaccines, separated by at least 30 days, are required. Vaccines for measles must have been given after 1967. For vaccines given before 1968, proof must be submitted that a live-virus vaccine was administered.
6. Vaccines for Measles, Mumps, and Rubella must have been given after the student's first birthday.
7. All internation (non-U.S. citizen status) students must provide (3) dose dates for Tetanus/diptheria immunizations. The last dose must be within the last ten (10) years.
8. Exemptions from vaccine requirements may be made in the following circumstances:
   • MEDICAL CONTRAINDICATIONS: a written, signed, and dated statement from a physician stating the vaccine that is contraindicated, the nature, and duration of the medical condition that contraindicates the vaccine(s). This statement will not be accepted if it does not meet the standards of care at The University of Chicago Hospitals.
   • RELIGIOUS EXEMPTION: a written, signed, and dated statement provided by the church describing their objection based upon bona fide religious tenets or practice. Request for religious exemptions will be forwarded for review and only be granted by the Dean’s office.
   • PREGNANCY OR SUSPECTED PREGNANCY: a signed statement from a physician stating the student is pregnant or pregnancy is suspected. Pregnancy exemptions are applicable only to Measles, Mumps, and Rubella requirements.
   • AGE EXEMPTION: persons born before January 1, 1957 are considered immune. Requirements may be met by the submission of a copy of the student's birth certificate, driver's license, or passport identifying the birthdate.

Anyone with a vaccine exemption may be excluded from the Seminary in the event of a Measles, Mumps, Rubella or Diphtheria outbreak in accordance with public health law.
Part I – To Be Completed by Student

Full Name: _____________________________________________________________

Date of Birth: __________ Degree Program: _______________ Term: ____________

Please read instructions on the reverse side carefully.

Part II – To Be Completed by Health Care Provider(s)*

ALL DATES MUST INCLUDE MONTH AND YEAR.

A. Measles (Rubeola): (At least one of the following must be documented.)
   1) a) First immunization with live attenuated virus (given on or after student’s first birthday), AND
      b) Second immunization with live attenuated virus (given at least 30 days after first immunization)
   2) Immunity Confirmed by blood titer. (Must attach copy of laboratory test in English.)
   3) Disease confirmed by Physician’s Records

B. German Measles (Rubella): (At least one of the following must be documented.)
   1) Immunization with live attenuated virus (given on or after student’s first birthday)
   2) Immunity Confirmed by blood titer. (Must attach copy of laboratory test in English.)

C. Mumps: (At least one of the following must be documented.)
   1) Immunization with live attenuated virus (Given after 1967 and given on or after student’s first birthday)
   2) Immunity Confirmed by blood titer. (Must attach copy of laboratory test in English.)
   3) Disease confirmed by Physician’s Records

D. Tetanus/Diptheria:
   1) Primary series completed (at least two dose dates for international students).
   2) Most recent tetanus booster. (Within last 10 years for ALL STUDENTS.)

Provider Signature(s)_________________________________________________________

Provider Name(s) (please print) _______________________________________________________

Address(es) ____________________________City/State/Zip

**Provider=Physician licensed to practice medicine in all of its branches (M.D. or D.O.), or Licensed Nurse, or a Public Health Official.