TheChicagoSchool®

WASHINGTON, D.C. IMMUNIZATION GUIDELINES

**THIS FORM MUST BE COMPLETED PRIOR TO THE STUDENT'S FIRST ENROLLMENT.
RETURN FORM TO THE OFFICE OF ADMISSIONS OR FAX TO +1-202-330-5277.**

The DC Department of Health requires confirmation of immunization for all degree students under the age of 26. The following immunizations or tests are required: Tetanus/Diphtheria (Td), Measles/Mumps/Rubella (MMR), Hepatitis B (HepB), and Varicella (Chicken Pox).

1. All dates must include *Month, Day, and Year* - If it cannot otherwise be determined that the specific vaccine(s) was administered at the minimally acceptable age or dosage interval.

2. Part II: Proof of immunity may be provided by a copy of the student's Certificate of Health Examination from a school which provides the complete information necessary to assure compliance with the Act.

3. Part III: Must be completed and signed by a health care provider*
   - All laboratory evidence of immunity must be accompanied by a copy of the laboratory report.
   - History of rubella disease is not acceptable as proof of immunity.
   - All live virus vaccines must have been given on or after the first birthday.
   - Mumps titer is only acceptable as proof of immunity if the laboratory test used was neutralization, enzyme-linked immunosorbent assay (ELISA or EIA) or radial hemolytic antibody test. A four-fold rise in antibody titer between appropriately spaced acute and convalescent sera is also acceptable.

4. Only the following exemptions will be accepted and documentation must accompany this record:
   - Medical contraindications: A written, signed, and dated document from a physician stating the specific vaccine or vaccines contraindicated and duration or medical condition that contraindicates the vaccine(s).
   - Religious exemption: A written, signed, and dated document by the student (or parent/guardian if the student is a minor) describing his/her objection to immunization on the grounds that they conflict with the tenet and practices of a recognized church or religious organization, of which the student is an adherent member.
   - Pregnancy or suspected pregnancy: A signed document from a physician stating the student is pregnant or pregnancy is suspected.

5. Anyone with a vaccine exemption may be excluded from the school in the event of a measles, rubella, mumps, or diphtheria outbreak in accordance with public health recommendations.

6. In some cases, students may be exempt from this process. Students born on or before January 1, 1957, women who are currently pregnant or those with religious objections are encouraged to contact the Office of Admissions at dcadmissions@thechicagoschool.edu for additional instructions.

7. All records not in English must be accompanied by a certified translation.

* Physician licensed to practice medicine; a local health authority; registered nurse employed by a school, college, or university; or a State Health Department recognized vaccine provider.

CERTIFICATE OF IMMUNITY

Part I - TO BE COMPLETED BY STUDENT

Last Name (Print)	First	Middle Initial	Social Security Number (SSN)

Date of Birth (M/D/Y)	Sex	Phone #	Term of Admission (Pick 1)
	☐ M ☐ F	( )	☐ Fall ☐ Spring ☐ Summer20

Compliance by Copy of Certificate of Health Examination Attached (Check here) ☐

I authorize *The Chicago School* to release this immunization record to the DC Department of Public Health, or its representatives, for compliance audits and in the event of a health or safety emergency.

STUDENT SIGNATURE: ________________________ **DATE**: ________________

PART II - *TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER. ALL DATES MUST INCLUDE MONTH, DAY, & YEAR.**

Health Care Provider or official of the designated record keeping office verifying that the above information is complete and correct to the best of my knowledge.

Tetanus/Diphtheria (Td)	**Yes**		
Primary series completed? Should include at least 2 doses— indicate month, day, and year.	☐	Date:	Date:
Most recent booster? Must be within 10 years.	☐	Date:	Physician's Signature:
Exemption?	☐	**Attach Physician's Statement**	
Measles/Mumps/Rubella (MMR)	**Yes**		
Immunization with live virus vaccine? (Given in 1968 or later)	☐	Dose #1 Date:	Dose #2 Date:
Diseases confirmed by physician's records?	☐	Date of Illness: (Must provide laboratory evidence)	Physician's Signature:
Immunity confirmed by blood titer?	☐	Date of Test:	**(Attach copy of laboratory report)**
Exemption?	☐	**Attach Physician's Statement**	
Hepatitis B (Hep B)	**Yes**		
Immunization with live virus vaccine?	☐	Date:	Physician's Signature:
Immunity confirmed by blood titer?	☐	Date of Test:	**(Attach copy of laboratory report)**
Exemption?	☐	**Attach Physician's Statement**	
Varicella (Chicken Pox)	**Yes**		
Immunization with live virus vaccine?	☐	Date:	
Disease confirmed by physician's records?	☐	Date of Illness:	Physician's Signature:
Immunity confirmed by acceptable laboratory test?	☐	Date of Test:	**(Attach copy of laboratory report)**
Exemption?	☐	**Attach Physician's Statement**	

Name (Print):		**Signature:**			
Address:		**Telephone:**		**Date:**	

*Physician licensed to practice medicine in all of its branches, a local health authority, registered nurse employed by a school, college, or university, or a Department recognized vaccine provider.

FOR OFFICE USE ONLY

All requirements complete: ☐ Yes ☐ No if No, date student notified: _____ Processed by: _____ Database entry date: _____ Date received: _____