Blackburn COLLEGE

Certificate of Immunity Form

This form to be returned to:
Student Life Office
Blackburn College
Carlinville, IL 62626
Fax: 217-854-5522

PART I – To be completed by student:

Last name (please print) First M.I.

Date of Birth (Mo/Day/Yr)	Sex	Home Phone Number
	M F	( )

PART II – Compliance by Copy of Certificate of Child Health Examination Attached (Check Box) ☐

PART III – To be completed and signed by health care provider. All dates must include MONTH, DAY, and YEAR:

DOSE	1 MO	DAY	YR	2 MO	DAY	YR	3 MO	DAY	YR	4 MO	DAY	YR	5 MO	DAY	YR
Diptheria, Pertussis and Tetanus (DPT)															
Diptheria and Tetanus (Td) or (TD)															
Oral Polio															
Combined Measles/ Mumps/Rubella (MMR)															
Combined Measles and Rubella (MR)															
Rubeola (Red Measles) Live Virus Vaccine															
Rubella (3 Day or German Measles)															
Mumps															

Health Provider Signature (Physician, School Health Professional or Health Official) verifying that Immunizations were given.

Telephone(____)_____

Name(print)_____

Signature_____

1. Clinical diagnosis is accepted if verified by physician.

Measles_____
Month Day Year

Mumps_____
Month Day Year

2. Laboratory confirmation of any disease is acceptable.

Disease _____
_____
Month Day Year

Lab Result _____

_____
Signature Date

_____
Signature Date

PART IV – Releases:

I authorize Blackburn College to release this immunization record to the Illinois Department of Public Health or its designated representative for compliance audits and in the event of health or safety emergency.

*Student's Signature*_____ *Date*_____

To be in completed by parent of legal guardian if student is under 18 years of age. I hereby give my permission for my child to receive any necessary immunizations or have herein provided information as the why I will not allow permission.

*Signature of Parent or Guardian*_____ *Date*_____

For Office Use Only

Reviewed by_____ Date_____ Complete ☐ Incomplete ☐