2023 – 2024 Saint Xavier University CERTIFICATE OF IMMUNITY FORM

Submission Deadlines: Fall - Sept 1, Spring – Feb 1, Summer - May 1

Last Name	First	Middle	University Identification Number	
Home Address			Preferred Phone ( )	Alternate Phone ( )
City/State/Country/Zip or Postal Code			E-mail Address	
Date of Birth (mm/dd/yyyy)	Age	Gender	First Semester at SXU	

🡻 🡻 🡻 This section must be completed by a Licensed Health Care Provider. 🡻 🡻 🡻

REQUIRED IMMUNIZATIONS (dates required)

Licensed Provider: Complete Immunization documentation OR attach signed physician/school immunizations.

■ **MEASLES-MUMPS-RUBELLA** – 2 shots against measles, 2 shots against rubella, and 2 shots against mumps for students born after January 1, 1957

MMR (strongly recommended) 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1 mm/dd/yy 2 mm/dd/yy	***OR***	**MEASLES (Rubeola)** 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1 mm/dd/yy 2 mm/dd/yy
Positive serum titers are also acceptable proof of immunity against measles, mumps and rubella. ☐ Required lab report attached.			**MUMPS** 2 doses at least 28 days apart AND after 12 months of age	1 mm/dd/yy 2 mm/dd/yy
Documentation of dates of disease **IS NOT** acceptable evidence of immunity against measles, mumps or rubella.			**RUBELLA** 2 doses at least 28 days apart AND after 12 months of age	1 mm/dd/yy 2 mm/dd/yy

■ **TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DT, DTaP, Td, Tdap) –**
At least 3 doses of diphtheria, tetanus and pertussis containing vaccine are REQUIRED. One dose MUST be Tdap.
The last dose of vaccine (DPT, DTP, DT, DTaP, Td, Tdap) must have been administered within 10 years of the student's enrollment date.
TITERS ARE NOT ACCEPTABLE TO FULFILL THIS REQUIREMENT

1 ***(record first shot here)***	2	3
☐ DTP / DTaP ☐ Tdap ☐ Td mm/dd/yy	☐ DTP / DTaP ☐ Tdap ☐ Td mm/dd/yy	☐ Tdap ☐ Td mm/dd/yy

■ **MENINGOCOCCAL CONJUGATE VACCINE** – Menactra or Menveo **is REQUIRED** for all students 21 and younger. A 2nd vaccine **MUST** be given if the 1st vaccine was given before age 16.	1 mm/dd/yy 2 mm/dd/yy

HIGHLY RECOMMENDED IMMUNIZATIONS (complete if received)

☐ **COVID-19:**	1st dose: ☐ Pfizer ☐Moderna ☐J&J ☐Novavax mm/dd/yy	2nd dose: ☐ Pfizer ☐Moderna ☐J&J ☐Novavax mm/dd/yy	Bivalent: ☐ Pfizer ☐Moderna mm/dd/yy

☐ **MENINGOCOCCAL B:** ☐ Trumenba ☐ Bexsero	1 mm/dd/yy	2 mm/dd/yy

Required Healthcare Provider Verification

Provider Name (print or stamp)	Signature	Date
Address		Phone

TO SUBMIT FORM: Upload to Patient Portal at sxu.medicatconnect.com –OR- **Drop off** at Health Center –OR- **Fax to** (773) 298-3906 ***QUESTIONS??:*** Call the SXU Health Center at (773) 298-3712 (M-F)

☐ Incomplete Date:_____ Initial: _____ ☐ Complete Date: _____ Initial: _____ Entered by: _____ Hold Off: ____ Scanned by: _____