

May 2, 2019

Dear ICO Class of 2023,

Warm greetings from ICO! Wanted to touch base about something we ask you address prior to matriculation. ICO has several immunization requirements for incoming students. Some are required by the State of Illinois for all college students while others fulfill the infection control policies of the college's clinic – the Illinois Eye Institute. As a burgeoning healthcare provider these requirements protect you but also your future patients.

ICO's Required Immunizations form lists all the required immunizations. You can take this form to your healthcare provider and have them document the requirements on the form itself. Sometimes students will have a combination of *official* sources for the records and that is ok. You can get started on this process right away because it needs to be completed on or before July 12, 2019.

We require our students create an account with Castle Branch. This is an outside service that provides life-long document storage, but also verifies that you've met the immunization requirements and will remind you if you need to update the immunizations. The actual webpage you'll need to visit to set up your personalized account is <https://portal.castlebranch.com/IL42>. This is where you go and select "I need to order my immunization tracking package". There is a \$35 fee to set up the account. Once you set up the account through Castle Branch you simply upload the ICO Immunization Record (or other official documentation). They review and approve or notify you of any deficiencies.

In a nutshell, here's what is required:

- **Measles Mumps Rubella (MMR)** – 2 doses of the vaccine (after 1st birthday) OR titers to prove immunity (must have lab report)
- **Tetanus / Diphtheria / Pertussis** – 3 doses of vaccine with the most recent being a Tdap. The most recent has to be less than 10 years ago.
- **Hepatitis B Virus (HBV)** – 3 doses of the vaccine OR titer to prove immunity (must have lab report)
- **Varicella** – 2 doses of the vaccine at least 28 days apart OR titer to prove immunity (must have lab report). History of disease is not in itself sufficient proof.
- **Tuberculosis** – 1 recent (in the 2019 calendar year) negative skin test (PPD or Mantoux test) OR Tspot / Quantiferon Gold testing, OR if patient is a positive responder, evaluation/chest x-ray with report by provider.
- This one applies only if you are 21 years of age or younger at the start of classes (8/12/19) – 1 dose of **Meningitis** vaccine (must be after your 16th birthday).

Seasonal influenza vaccination is required during enrollment, but **does not** need to be provided prior to enrollment. The flu shot is offered on campus during the fall and winter months.

If you have any questions, please reach out to me at BKarmis@ico.edu!

Take care,

Beth A. Karmis, M.A.

Sr. Dir. of Student Development



How to Place Order

Welcome to **my**

To place your order go to:






Package Name (if applicable):

PLACE ORDER

SELECT PROGRAM

SELECT PACKAGE

To place your initial order, you will be prompted to create your secure myCB account. From within myCB, you will be able to:

-  View order results
-  Upload documents
-  Manage requirements
-  Place additional orders
-  Complete tasks

Please have ready personal identifying information needed for security purposes.

The email address you provide will become your username.

Contact Us: **888.914.7279** or **servicedesk.cu@castlebranch.com**



ILLINOIS COLLEGE OF OPTOMETRY

3241 S. Michigan Ave.
Chicago IL 60616
(312) 949-7415 - PHONE
(312) 949-7391 - FAX

Required Immunization Record

Verification Deadline is July 12, 2019

Part I (ICO Student Completes This Section)

Last Name _____ First Name _____ Middle Initial _____
(please print)

Date of Birth ____/____/____ ICO ID # _____ Class of **2023**
Month Day Year

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

Student Signature _____ Date _____

Part II (Health Care Provider Completes This Section)

All information must be in **English**. All dates must include **month, day, and year**.

M.M.R. (Measles, Mumps, Rubella)

(Two doses required *after 1st birthday* at least 28 days apart)

1. Dose 1 given after 1st birthday or later.....#1 ____/____/____
Month Day Year

2. Dose 2 given at least 28 days after Dose 1.....#2 ____/____/____
Month Day Year

Serologic testing confirming immunity will be accepted in lieu of documentation of vaccinations. Copy of official **lab results must be attached to this form**.

Tetanus/Diphtheria

All students must document a total of (3) three doses of Diphtheria, Tetanus, and Pertussis (DTP or DTaP), pediatric Diphtheria and Tetanus (DT), adult Tetanus and Diphtheria (Td) or Tetanus, Diphtheria and Acellular Pertussis (Tdap). You must have had a Tdap within past 10 years (after 8/12/2009).

#1 ____/____/____ #2 ____/____/____ #3 Tdap ____/____/____
Month Day Year Month Day Year Month Day Year

Hepatitis B Virus

(Three doses or a positive hepatitis B surface antibody meets the requirement)

1. Immunizations #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
Month Day Year Month Day Year Month Day Year

Serologic testing confirming immunity will be accepted. **Lab results MUST be attached to this form**.

Hepatitis B surface antibody Date ____/____/____ Result: Reactive____ Non-reactive____
Month Day Year

Meningococcal Conjugate Vaccine

This requirement applies only to incoming students are **21 or younger** (as of August 12, 2019) - required to have had one dose of Meningococcal Conjugate Vaccine. The dose must be after the student's 16th birthday, but before July 12, 2019.

1. Single Dose of Meningococcal Conjugate Vaccine.....____/____/____
Month Day Year

Last Name _____ First Name _____

Baseline Tuberculosis Screening

One (1) Mantoux tuberculin skin test (TST) administered between January 1, 2019 and July 12, 2019. You will be screened for symptoms annually hereafter. People with positive skin test, provide evaluation of your current TB status. Please note that history of BCG is NOT a contraindication for TB testing.

Admin. Date: ____/____/____ Read Date: ____/____/____ Result: _____ mm (If no induration, write "0")
Month Day Year Month Day Year

Interpretation: positive _____ negative _____

OR:

INTERFERON GAMMA RELEASE ASSAY (IGRA) Test Date _____

Lab report must be included

To be completed by health care provide in the event of positive TB test or history of TB

Positive Test History Requires Chest X-ray Result: normal _____ abnormal _____

Date of chest x-ray: ____/____/____ *X-Ray report must be attached to this form.
Month Day Year

Varicella

(2 doses of vaccine or positive varicella antibody)

1. Dose 1#1 ____/____/____
Month Day Year
2. Dose 2 given at least one month after first dose#2 ____/____/____
Month Day Year

History of disease is **insufficient** indicator of immunity. If individual has had disease, serologic testing confirming immunity will be accepted. **Lab results must be attached to this form.**

3. Varicella antibody ____/____/____ Result: Immune _____ Non-immune _____
Month Day Year

HEALTH CARE PROVIDER TO COMPLETE:

TO THE BEST OF MY KNOWLEDGE, THIS STUDENT HAS RECEIVED ALL THE ABOVE IMMUNIZATIONS AND TB TESTS.

Name _____ Address _____
(Physician, Nurse or School Health Authority)

Signature _____ Phone _____

ANY TITERS OR LABS? MUST ATTACH LAB REPORT TO THIS FORM.