IMMUNIZATION FORM—REQUIRED FOR MATRICULATION

Student's Name _____ STUDENT ID#_____

Student's Date of Birth_____

Persons born before January, 1957, are exempt from this requirement and do not need to submit this form.

All Commuter and Resident students MUST have Sections A and E OR Sections B, C, D, and E completed in order to be in compliance with the NY State Public Health Laws.

Month / Day / Year

A: M.M.R. (Measles, Mumps, Rubella) if given instead of individual immunizations

1st Dose: Immunized on or after first birthday, AND on or after January 1, 1972 ____/____/____

2nd Dose: Immunized 15 months after birth or later, AND at least 28 days after 1st dose. ____/____/____

B: MEASLES (RUBEOLA) – Complete #1, 2, or 3

1. ____ History of Illness documented by Health Care Provider ____/____/____
2. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
3. ____ Dose 1: Immunized on or after first birthday, AND on or after January 1,1968 ____/____/____
   AND Dose 2: Immunized 15 or more months after birth AND at least 28 days after 1st dose. ____/____/____

C: MUMPS (PAROTITIS) – Complete #1, 2, or 3

1. ____ History of Illness documented by Health Care Provider ____/____/____
2. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
3. ____ Immunized on or after first birthday, AND on or after January 1,1968 ____/____/____

D: RUBELLA (GERMAN MEASLES) – #Complete 1 or 2

1. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
2. ____ Immunized on or after first birthday, AND on or after January 1,1968 ____/____/____

E: MENINGOCOCCAL MENINGITIS – Response required for ALL Students

Check one box.

☐ I have had the meningitis immunization (Menomune™/Menactra ™) within the past 10 years. ____/____/____

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

F. OPTIONAL, BUT STRONGLY RECOMMENDED FOR RESIDENT STUDENTS

_____ PPD Result _____ ____/____/____

_____ Tetanus or TD (within 10 years) ____/____/____

_____ Polio Series Completes ____/____/____

_____ Hepatitis #1 ____/____/____

#2 ____/____/____

#3 ____/____/____

____ Varicella (*If No History of the Chicken Pox*) ____/____/____

Physician's Signature _____ Date: _____

Physician/Provider Stamp & Lic. #_____Office phone #:_____

Remit to Gabrielle Russin (Rangos 116 or grussin@svots.edu) before the first Friday of the semester.