ST VLADIMIR'S ORTHODOX THEOLOGICAL SEMINARY
575 Scarsdale Rd. • Yonkers, New York 10707 • TEL 914.961.8313 • FAX 914.961.4507 • www.svots.edu

IMMUNIZATION FORM

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

Student's Name: _____ STUDENT ID#_____

Student's Date of Birth: _____

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.

A: M.M.R. (Measles, Mumps, Rubella) if given instead of individual immunization Month / Day / Year

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 & License # _____ Office phone #:_____

Please return this form to Gabrielle Russin, *Student Affairs Administrator,* by Friday, August 28, 2020.