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—REQUIRED FOR MATRICULATION

Student's Name _____ 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. #_____

Physician/Provider Email & Phone #:_____

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