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

Student Name: _____ **DOB:** _____

Required for Matriculation. All Commuter and Residential students MUST have Sections *A and E* OR Sections *B, C, D, and E* completed in order to be in compliance with the New York 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**	Month / Day / Year
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	Month / Day / Year
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	Month / Day / Year
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.	Month / Day / Year
☐ I have had meningitis immunization *(such as Menactra, Menveo, or MenQuadfi)* within the past 5 yrs.	____/____/____

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

Student's signature: _____ Date: _____

F. OPTIONAL, BUT STRONGLY RECOMMENDED FOR RESIDENT STUDENTS			Month / Day / Year
☐ 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: _____ Today's Date: _____

Physician/Provider Stamp & License #: _____

Physician/Provider Email and Phone #: _____

Please remit this form to registrar@svots.edu by the first day of the fall semester.