IMMUNIZATION RECORD

The College of Saint Rose

Name:_____ Student ID: _____

Address:_____ Phone: _____

City:_____ Cell: _____

State:_____ Zip:_____ Date of Birth: _____

HEALTH CARE PROVIDER OR SCHOOL OFFICIAL PLEASE READ AND COMPLETE THIS FORM, THANK YOU.

New York State Public Health Law 2165 requires post-secondary students to show proof of immunity to **MEASLES, MUMPS and RUBELLA**. *Persons born prior to January 1, 1957 or taking less than six credits in a semester are exempt from this requirement.* **Immunization #1 in Option 1 must have been given after the first birthday**.

REQUIRED VACCINES (Option 1 or 2) :

Option 1: Two Doses of Measles, Mumps, Rubella (MMR) Vaccine - (Dose #1 given **after** First birthday)

MMR #1_____/_____/_____ AND MMR #2 _____/_____/_____

Month Day Year Month Day Year

Option 2: Positive MMR Antibody Titers

( ) ✓ Positive MMR Antibody Titers
MUST ATTACH COPY OF LAB REPORT
Attached certificates of immunization will be ***Accepted ONLY IF signed stamped by health care provider****.*

RECOMMENDED VACCINES:

Tetanus____/____/____ Hepatitis B Series: ____/____/____,____/____/____,____/____/____

Varicella____/____/____,____/____/____

Attached certificates of immunization will be accepted ***ONLY IF*** *signed/stamped by health care provider*

Health Care Provider Signature/Stamp Required. Include professional designation:

Print Name & Title_____ Date_____

Signature_____ Phone _____

Address _____ Stamp

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HEALTH SERVICES • 432 WESTERN AVE. ALBANY, NY 12203