



## CERTIFICATE OF IMMUNIZATION

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Phone No. (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_

New York State Public Health Law requires all students born after 1956 and enrolling for more than 5 credit hours to prove immunity to measles, mumps and rubella. All immunizations must be administered after 1967, on or after the first birthday, and a minimum of 30 days apart. Exceptions to this requirement will be made for students with genuine and sincere religious beliefs contrary to immunization or for those for whom immunization medically contraindicated.

### Proof of Immunity

2 measles, 1 mumps and 1 rubella immunization OR serology demonstrating proof of immunity to measles, mumps and rubella, OR, history of disease (must have date) for measles and mumps signed by diagnosing physician. History of rubella illness is not acceptable.

#### IMMUNIZATION

OR

#### SEROLOGY

MMR date 1 \_\_\_\_\_ date 2 \_\_\_\_\_

Measles date \_\_\_\_\_ result

Measles date \_\_\_\_\_ date 2 \_\_\_\_\_

Mumps date \_\_\_\_\_ result

Mumps date \_\_\_\_\_ Rubella date \_\_\_\_\_

Rubella date \_\_\_\_\_ result

#### HISTORY OF DISEASE please list date of illness

( ) Measles \_\_\_\_\_ ( ) Mumps \_\_\_\_\_

Signature of Diagnosing Physician \_\_\_\_\_

#### RECOMMENDED

\* Meningitis Vaccination Date \_\_\_\_\_ Tetanus Date \_\_\_\_\_ (within 10 yrs)

Quadravalent polysaccharide vaccine (Menomune)  Polysaccharide Diphtheria Toxoid Conjugate Vaccine (Menactra)

Hepatitis B Date #1 \_\_\_\_\_ Date #2 \_\_\_\_\_ Date #3 \_\_\_\_\_

#### SIGNATURE OF HEALTH CARE PROVIDER completing form:

\_\_\_\_\_ Date \_\_\_\_\_

\*New York Public Health Law requires that all college students enrolled for 6 hours or more be provided with information on meningitis and meningitis vaccine and either provide proof of meningitis vaccine within the last 10 years or decline immunization.

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 (my child) will not obtain immunization against meningitis disease.

Signature \_\_\_\_\_ Date \_\_\_\_\_

This form must be completed and returned to Health Services or students will be restricted from registration and or class attendance.

Please return form to Health Services at Onondaga Community College, 4585 West Seneca Turnpike, Syracuse New York 13215-4585 Phone No. (315) 498-2599 Fax No. (315) 469-9270