

# Schenectady County Community College

## IMMUNIZATION CERTIFICATE FOR STUDENTS

New York State Public Health Law requires that **all** students enrolled in six (6) credit hours or more, whose birth date is on or after January 1, 1957, **MUST** provide official documentation of immunizations. A student **NOT** in compliance with the law within 30 days of the beginning of the semester **WILL** be withdrawn from the College with loss of the semester's course credit and no tuition refund, and will not be permitted to register for an ensuing semester until proof of immunity is provided to:

Schenectady County Community College  
Student Services Office,  
222 Elston Hall  
78 Washington Avenue  
Schenectady, New York 12305

**MEASLES (Rubeola):** **Two** doses of live vaccine given after 1967 and administered on or after the first birthday and **second** dose after 15 months of age and at least 28 days from first dose. Combined MMR is recommended for both doses; **OR** physician's diagnosis of disease; **OR** a blood titer.

**MUMPS:** **One** dose of live vaccine given after 1968 and administered on or after the first birthday; **OR** physician's diagnosis of the disease; **OR** a positive blood titer.

**RUBELLA (German Measles):** **One** dose of live vaccine given after 1968 and administered on or after the first birthday; **OR** a positive blood titer test.

**MENINGOCOCCAL MENINGITIS:**

- A record of meningococcal meningitis immunization within the past 10 years; **OR**
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or student's parent or guardian.

**EARLY CHILDHOOD MAJORS ONLY Additional Immunization Information:**

- **HEPATITIS B** (*recommended*)
- **TUBERCULIN TEST** (**required**)
- **TETANUS-DIPHTHERIA** (*recommended*)
- **PHYSICIAN'S STATEMENT** verifying student's ability to work with children (**required**)

**TO OBTAIN IMMUNIZATION INFORMATION:** Request and obtain high school immunization/health record, the Certificate of Immunization Form must be completed and signed by your health care provider/physician.

Return form to Schenectady County Community College (address above) **by the first day of classes.**

**For more information, contact the Student Services Office Phone: (518) 381-1344 OR Fax: (518) 381-1477**

**NOTE:** *To assist with your needs, Schenectady County Public Health Services, 107 Nott St, Suite 204, offers immunization clinics for Schenectady county residents. Call 346-2187 to schedule an appointment.*

# Schenectady County Community College

## IMMUNIZATION CERTIFICATE FOR STUDENTS

Semester: Fall \_\_\_\_\_ Spring \_\_\_\_\_ Summer \_\_\_\_\_ Academic Year \_\_\_\_\_

Student Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student Address \_\_\_\_\_  
Last First Initial

Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**DIRECTIONS:** The Certificate of Immunizations Form must be completed and signed by your health care provider/physician and returned to: **Schenectady County Community College , Student Services Office, 222 Elston Hall, 78 Washington Ave, Schenectady, New York 12305 Phone: (518) 381-1344 Fax: (518) 381-1477/381-1456**

**REQUIRED Immunizations** (Note: Persons born prior to 1/1/57 are exempt from this requirement.)

**MEASLES Documentation** of TWO dates of Measles (Rubeola) Immunizations Dose 1 \_\_\_\_\_  
Both must be given after 1967. Month / Day / Year  
One, on or after the first birthday, and 2<sup>nd</sup> dose given at least 28 days after 1<sup>st</sup>. Dose 2 \_\_\_\_\_  
Month / Day / Year

**OR: Documentation** of Measles Titer (blood test showing immunity)  
Results \_\_\_\_\_ Date \_\_\_\_\_

**OR: Documentation** of measles disease Date \_\_\_\_\_

**MUMPS Documentation** of Immunization Dose \_\_\_\_\_  
Must be given on or after the first birthday, and after 1968. Month / Day / Year

**OR: Documentation** of Mumps Titer (blood test showing immunity)  
Results \_\_\_\_\_ Date \_\_\_\_\_

**OR: Documentation** of mumps disease Date \_\_\_\_\_

**RUBELLA Documentation** of Immunization Dose \_\_\_\_\_  
Must be given on or after the first birthday, and after 1968. Month / Day / Year

**OR: Documentation** of Rubella Titer (blood test showing immunity)  
Results \_\_\_\_\_ Date \_\_\_\_\_

**MENOMUNE/MENINGOCOCCAL MENINGITIS** Vaccine date: \_\_\_\_\_

**OR: Student** (Parent/Guardian if student is under the age of 18) **must sign the statement below:**  
I have read or have had explained to me the information regarding meningococcal meningitis disease. I (my child, if under age 18) understand the risks of not receiving the vaccine and a decision has been made not to obtain immunization against meningococcal meningitis disease. Signed/dated \_\_\_\_\_

**EARLY CHILDHOOD STUDENTS ONLY - Additional Immunization Information**

**HEPATITIS B** (Recommended) Date of 1<sup>st</sup> dose: \_\_\_\_\_ 2<sup>nd</sup> Dose: \_\_\_\_\_ 3<sup>rd</sup> Dose: \_\_\_\_\_

**TETANUS-DIPHTHERIA** (Recommended) Date: \_\_\_\_\_

**TUBERCULIN** (Required) Date: \_\_\_\_\_

**PHYSICIAN'S STATEMENT (Required) verifying student's ability to work with children:**

The above named individual (check one):  Is  Is not able to work with children.

COMMENTS: \_\_\_\_\_

Print Physician's Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_