SUNY Schenectady County Community College
Student Affairs, Elston Hall 222
78 Washington Avenue
Schenectady, New York 12305

STUDENT IMMUNIZATION RECORD FORM

All students enrolled in six (6) credit hours or more, whose birth date is on or after January 1, 1957, MUST comply with immunization requirements. Immunization information must be received by Student Affairs, Elston Hall 222 in person, by mail to the above address, by fax to: 518-381-1456 or sent via email to immunizations@sunysccc.edu before the student attends the first class. Please call 518-381-1344 with questions.

Name_____ Date of Birth _____ Student ID_____

Semester_____ Year_____ Phone Number_____ Email _____

Required: Two doses of the **MMR** immunization, given after 12 months of age with the second dose at least one month after the first dose **or** blood tests showing immunity to all three illnesses.

MMR - Date of first dose_____ **MMR - Date of second dose_____**

If administered separately:

Measles (Rubeola) Two doses required: Vaccine Date _____Vaccine Date_____

Mumps Vaccine Date _____ or Disease History_____

Rubella Vaccine Date _____ or Disease History_____

or

Titer – Blood test - results from this test are useful for people who are not sure if they have been vaccinated or need to prove they have immunity from prior vaccinations.

Measles (Rubeola) Titer Date _____ Result_____

Mumps Titer Date _____ Result _____

Rubella Titer Date _____ Result _____

Required: One dose of the Meningococcal immunization given within the last 5 years; **or** a complete two dose series **or** a signed waiver. New York State Department of Health requires each student to indicate meningitis compliance by providing a waiver of the vaccine OR providing medical documentation of date of vaccine.

Meningococcal Vaccine for Meningitis Vaccine Date _____Vaccine Date_____

WAIVER: I have reviewed the information regarding meningococcal disease. I am fully aware of the risks associated with this disease and of the availability and effectiveness of the vaccine. I have elected NOT to get the vaccine.

_____

Signature of Student (Parent/Guardian if student is under 18) Date

Physician Comments_____

Physician Name (Printed)_____Signature_____Date_____

Address and Phone number:_____

We accept proof of immunizations from medical offices, high schools and universities. If you are providing an immunization report from your doctor's office, school or university, it is not necessary to have this form signed or to return this form as long as you have met the MMR and Meningitis requirement.