



REQUIRED IMMUNIZATION FORM

IMMUNIZATION REQUIREMENTS FOR REGISTRATION

Due to regulations mandated by the Board of Regents, all students, who reside on campus or receive instruction on campus, must document their immune status for measles, mumps and rubella. "Proof of **two doses of measles, mumps and rubella vaccine**, or of separate vaccinations against all three diseases, or of the presence of immune antibody titers against measles, mumps and rubella shall be required." Students who fail to provide the required, signed proof of immunization shall not be permitted to register for or to attend classes at any state institution until they are in compliance. Students born before January 1957 are exempt from providing immunization documentation.

Name _____ Birth Date ____/____/____
Last First Middle Mo. Date Year

Soc. Sec. # ____/____/____ Phone (____) _____ Cell(____) _____

Address _____
Street City State Zip Code

REQUIRED IMMUNIZATIONS – Must be filled out and signed (below) by a Health Care Provider

Date of 1st Measles, Mumps, Rubella Immunization _____ **Date of 2nd Measles, Mumps, Rubella Immunization** _____
(Must be given after age 12 months) (Must be given at least 30 days after 1st MMR)

#1 MMR ____/____/____ **AND #2 MMR** ____/____/____

OR Separate Immunizations:

#1 Rubella ____/____/____ **AND** #2 Rubella ____/____/____
 #1 Rubeola ____/____/____ **AND** #2 Rubeola ____/____/____
 #1 Mumps ____/____/____ **AND** #3 Mumps ____/____/____

OR Titers:

Rubella Titer Date ____/____/____ **POSITIVE Result** _____ **Attach copy of Lab result**
 Rubeola Titer Date ____/____/____ **POSITIVE Result** _____ **Attach copy of Lab result**
 Mumps Titer Date ____/____/____ **POSITIVE Result** _____ **Attach copy of Lab result**

Signature _____ **Date** _____
(Must be signed by a Nurse, P.A. or Physician)

Address _____

MEDICAL EXEMPTION TO IMMUNIZATION REQUIREMENT

I certify that it would be harmful to this student's physical health to be immunized against measles, mumps, and rubella.

Reason for Exemption: _____

Check one: _____ Permanent Exemption

_____ Temporary Exemption – Date to be released: _____
Month Day Year

Physician's Signature _____ Date: _____

(Must be signed by a Physician)

RECOMMENDED IMMUNIZATIONS (Not required for registration)

Name: _____
Last First Middle

Tetanus-Diphtheria (Td) booster _____ / _____ / _____ or Tdap _____ / _____ / _____

Hepatitis B 1 _____ / _____ / _____ 2 _____ / _____ / _____ 3 _____ / _____ / _____

Meningitis _____ / _____ / _____

Varicella (Chicken Pox) Vaccine 1 _____ / _____ / _____ 2 _____ / _____ / _____

OR

Chicken Pox Disease (Date) _____ / _____ / _____

Tuberculosis – PPD (Mantoux) within the last year _____ / _____ / _____ Results: _____