MEDICAL PROVIDER DOCUMENTATION OF IMMUNIZATION

Student name _____ DOB: _____ H# _____

REQUIRED IMMUNIZATIONS: Students taking 6 or more credits must provide this completed form signed by your health care provider or comparable official records that show the dates you received the following immunizations.

Measles/Mumps/Rubella (MMR) - Complete Option 1 or Option 2.

Option 1: Two doses of live MMR administered on or after the first birthday (must have been given at least 28 days apart.)

- ◯ Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____

Option 2: If vaccines were given separately, select one each for Measles, Mumps, and Rubella.

Measles - Check one box only.

- ◯ Two doses of live vaccine administered on or after the first birthday (must have been given at least 28 days apart.
- ◯ Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____
- ◯ Protective antibody titer Date (mm-dd-yy) _____ Result o positive o negative
- ◯ Physician-diagnosed illness Date (mm-dd-yy) _____

Mumps - Check one box only.

- ◯ One dose of live vaccine administered on or after the first birthday. Date #1 (mm-dd-yy) _____
- ◯ Protective antibody titer Date (mm-dd-yy) _____ Result: o positive o negative
- ◯ Physician-diagnosed illness Date (mm-dd-yy) _____

Rubella - Check one box only. (Previous clinical diagnosis of rubella is not sufficient.)

- ◯ One dose of live vaccine administered on or after the first birthday Date (mm-dd-yy) _____
- ◯ Protective antibody titer Date (mm-dd-yy) _____ Result: o positive o negative

Meningococcal. Complete Option 1, 2, or 3.

Option 1: Meningococcal conjugate vaccine (including Menactra™, Menveo™, Menomune™, Meningococcal ACYW-135, or other). The date of your conjugate vaccine should be within the past 5 years.

- ◯ Meningococcal type/brand (if known) _____ Date (mm-dd-yy) _____

Option 2: Meningococcal Type B.

- ◯ Trumenba™ Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____ Date #3 (mm-dd-yy) _____
- ◯ Bexsero™ Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____

Option 3: Meningococcal waiver.

- ◯ I have decided not to obtain the meningococcal vaccine. I understand I must send a waiver documenting my decision. The form can be found at HVCC Health Services forms then download, complete, and return the Meningitis Information Sheet and Self reporting Form

RECOMMENDED IMMUNIZATIONS

If you have had any of the vaccines below, please supply the dates and have your health care provider sign this form. These immunizations are recommended by the U.S. CDC (Centers for Disease Control) and the American College Health Association. To protect your health, we urge students to receive these important vaccinations (or begin the series) before starting at HVCC.

Pertussis (Tdap).

- ◯ Tdap administered age 10 or later Date (mm-dd-yy) _____

Tetanus. If your Tdap vaccine was more than 10 years ago, you must enter a more recent tetanus booster. Check one box only. The date must be within the past 10 years.

- ◯ Td-adult Date (mm-dd-yy) _____
- ◯ Tetanus toxoid Date (mm-dd-yy) _____

Varicella (Chicken Pox). Two doses of vaccine administered on or after the first birthday (must have been given at least 28 days apart):

- ◯ Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____
- ◯ Protective antibody titer: Date (mm-dd-yy) _____ Result: o positive o negative
- ◯ Physician-diagnosed illness: Date (mm-dd-yy) _____

Hepatitis A Vaccine. Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____

Hepatitis B Vaccine. Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____ Date #3 (mm-dd-yy) _____

HEP A /HEP B Combined Vaccine.
Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____ Date #3 (mm-dd-yy) _____

Human Papillomavirus (HPV) Vaccine Series. (Recommended for students of all genders, 26 and under)
Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____ Date #3 (mm-dd-yy) _____

SUNY (State University of New York) no longer requires students to be vaccinated for COVID-19, however, all members of the campus community are strongly encouraged to do so, and to stay up to date on boosters as recommended by the CDC to protect themselves and others. Those who have received their vaccines and/or boosters are asked to continue to send their updated vaccination records using the proper Health Services form, to ensure correct recordkeeping.

NOTE: All students enrolled in an applied learning experience, program or course requiring a clinical or internship will still be needed to follow their host site policies, including any vaccination or testing protocols. This applies to students in any academic program and all levels of clinical and allied health training.

COVID-19 Vaccine. Type/brand _____
Date #1 (mm-dd-yy) _____ Date #2 (mm-dd-yy) _____
Booster (if applicable) _____

HIB Vaccine (Haemophilus Influenza B). Date (mm-dd-yy) _____

Pneumococcal Vaccine. Date (mm-dd-yy) _____

Polio Vaccine (before age 18). Check one box only.

- ◯ IPOL Date of most recent dose (mm-dd-yy) _____
- ◯ OPV Date of most recent dose (mm-dd-yy) _____
- ◯ EPV Dates
  DOSE #1 (mm-dd-yy) _____ DOSE #2 (mm-dd-yy) _____ DOSE #3 (mm-dd-yy) _____

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE

Signature _____ Date(mm-dd-yy) _____

Name_____ Work Phone _____
Last, first, middle *degree/title*

Address _____

Hudson Valley Community College Health Services
Siek Campus Center, Suite 270
(518) 629-7468
healthservices@hvcc.edu