NEW YORK THEOLOGICAL SEMINARY STUDENT IMMUNIZATION RECORD FORM

Name

Last
First
Middle

Student ID Number

Number on bottom of ID card

Home Address

Number & Street
Apt #
City
State
Zip

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New York State Public Health Law 2165 requires post-secondary students to show protection against measles, mumps and rubella. Persons born prior to January 1, 1957 are exempt from this requirement. An MMR vaccine is recommended for all measles vaccine doses to provide increased protection against all three vaccine-preventable diseases: measles, mumps and rubella.

PLEASE NOTE:
A LEGIBLE copy of an immunization record from a previous school attended (college, university) or a childhood immunization record will be acceptable proof of immunization if it clearly contains the required information.

REQUIRED: Measles (Rubeola) Immunity – Must have ONE of the following:

A. TWO dates of measles Immunization: (1) __________________________ (2) __________________________
   Both dates must be given after 1967; the first immunization after the first birthday and the second on or after 15 months of age.

B. Date of Measles Titer __________________________ Results: __________________________

C. Date of physician diagnosed measles disease __________________________
   Signature of diagnosing physician __________________________

REQUIRED: Rubella (German Measles) Immunity – Must have ONE of the following:

A. Date of at least one rubella immunization: (1) __________________________ (2) __________________________
   (Must be on or after the first birthday)

B. Date of Rubella Titer __________________________ Results __________________________
   Physician diagnosis is not acceptable.

REQUIRED: Mumps Immunity – Must have ONE of following:

A. Date of at least one mumps immunization: (1) __________________________ (2) __________________________
   (Must be on or after the first birthday)

B. Date of Mumps Titer __________________________ Results __________________________

C. Date of physician diagnosed mumps disease __________________________
   Signature of diagnosing physician __________________________

Name of Health Practitioner: __________________________ Signature __________________________

Date __________________________ Print

Health Practitioner’s Seal or Stamp