

**PROOF OF IMMUNIZATION FORM**

(VOID UNLESS ALL SECTIONS ARE SATISFACTORILY COMPLETED)

NEW YORK STATE PUBLIC HEALTH LAW REQUIRES ALL POST-SECONDARY STUDENTS BORN ON OR AFTER JANUARY 1, 1957 TO SHOW PROOF OF IMMUNITY TO MEASLES (RUBEOLA), MUMPS AND RUBELLA (GERMAN MEASLES).

NAME: \_\_\_\_\_ SS# \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
Last First Middle

MAILING ADDRESS: \_\_\_\_\_

ALL VACCINES MUST HAVE BEEN LIVE ATTENUATED DOSES TO BE ACCEPTABLE. MMR VACCINES ARE RECOMMENDED FOR ALL RE-VACCINATIONS.

**MEASLES/RUBEOLA IMMUNITY: TWO LIVE VACCINE DATES REQUIRED. FIRST VACCINE MUST BE AFTER 1967 AND AFTER YOU WERE EXACTLY 12 MONTHS OLD.**

FIRST VACCINE DATE: \_\_\_\_\_  
Month Day Year

MMR # 1 \_\_\_\_\_  
Month Day Year

SECOND VACCINE DATE: \_\_\_\_\_  
Month Day Year

MMR # 2 \_\_\_\_\_  
Month Day Year

**OR POSITIVE RUBEOLA TITRE (PLEASE ATTACH COPY OF LABORATORY REPORT)**

**OR PHYSICIAN-DIAGNOSED MEASLES/RUBEOLA DISEASE:**

Date of Diagnosis: \_\_\_\_\_  
Print Name of Diagnosing Physician: \_\_\_\_\_  
Signature of Diagnosing Physician: \_\_\_\_\_

**MUMPS IMMUNITY:**

A Mumps Vaccine Given After You Were Exactly 12 Months Old:

Vaccine Date: \_\_\_\_\_ OR POSITIVE MUMPS TITRE (PLEASE ATTACH COPY OF LABORATORY REPORT)  
Month Day Year

**OR PHYSICIAN-DIAGNOSED MUMPS DISEASE:**

Date of Diagnosis: \_\_\_\_\_  
Print Name of Diagnosing Physician: \_\_\_\_\_  
Signature of Diagnosing Physician: \_\_\_\_\_

**RUBELLA/GERMAN MEASLES IMMUNITY:**

A Rubella Vaccine Given After You Were Exactly 12 Months Old:

Vaccine Date: \_\_\_\_\_ OR POSITIVE RUBELLA TITRE (PLEASE ATTACH COPY OF LABORATORY REPORT)  
Month Day Year

**ADDITIONAL TESTING: MANTOUX TB SKIN TEST**

Date Administered: \_\_\_\_\_ Date Interpreted: \_\_\_\_\_ Result: \_\_\_\_\_

Hepatitis B Series Vaccination Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Date Form Completed: \_\_\_\_\_

Name of Health Practitioner: \_\_\_\_\_

Signature of Health Practitioner: \_\_\_\_\_

Please Affix Your Office Stamp: