



Student Immunization Record

Student's Name _____ Date of Birth _____

Program _____ Year of Graduation _____

The immunization record must be completed and signed by a licensed health care provider.

The following proof of immunity is required.

Live Virus Vaccines are not to be administered within 30 days of registration since this will invalidate required tuberculin skin test at registration. Required vaccines may be administered by Student Health at the expense of the student.

Rubella (German Measles):

Rubella Antibody Titer: **(Mandatory)** Date: _____ Result: _____ **Enclose copy of Laboratory Report**

Vaccine Administered: (If antibody titer is negative):

Date: _____ Product: _____ Provider Sig./Title: _____

Rubeola (Measles): (Required if born after January 1, 1957)

Rubeola Antibody Titer: **(Mandatory)** Date: _____ Result: _____ **Enclose copy of Laboratory Report**

Vaccine Administered: (If antibody titer is negative):

Date: _____ Product: _____ Provider Sig./Title: _____

Date: _____ Product: _____ Provider Sig./Title: _____

Mumps:

Mumps Antibody Titer: **(Mandatory)** Date: _____ Result: _____ **Enclose copy of Laboratory Report**

Vaccine Administered: (If antibody titer is negative):

Date: _____ Product: _____ Provider Sig./Title: _____

Varicella (chickenpox): One of the following indicators of immunity is required:

Varicella immunizations received:
Date: #1: _____
Date: #2: _____

OR

Varicella titer done:
Date: _____
Immune: <input type="checkbox"/> Yes <input type="checkbox"/> No
Enclose Copy of Laboratory Report

Tetanus: Recommended every 10 years. Vaccination date: _____

Hepatitis B: Recommended. Can be completed at SUNY Upstate Medical University

Dates: #1: _____ #2: _____ #3: _____

Antibody Titer date(if done) _____ Results: _____

Meningococcal Vaccine (optional). Vaccination Date: _____

Tuberculosis Screening: *DO NOT* place a tuberculin skin test. This will be done on campus at registration. Please supply the following information:

• Is there a history of past positive PPD? Yes No

If yes, date of conversion: _____ Reaction: _____

• Chest x ray is required for history positive PPD. It must be done within 6 months of registration. Enclose copy of **Radiology report**.

Date: _____ Result: _____

• Was treatment taken for a positive PPD Yes No

Drug: _____ Date Started: _____ Date Completed: _____

Print name of Health Care Provider: _____ Title: _____

Signature of Health Care Provider: _____ Date: _____

Health Care Provider's Address: _____ Telephone: () _____