

Immunization Record—submit by mail or fax

(for completion by non-Syracuse University students only)



Full Legal Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Social Security Number: _____

Country of Study _____

Syracuse University policy in accordance with New York State public health law requires all students to provide:

- Proof of immunity to measles, mumps, and rubella:
 - Dates of two doses of measles vaccine, or positive titer results, or physician documentation of disease and:
 - Date of one dose of rubella vaccine, or positive titer result and;
 - Date of one dose of mumps vaccine, or positive titer result, or physician documentation of disease.
- Note: persons born before January 1, 1957 are exempt from the measles, mumps, and rubella requirement.

- A completed response related to meningococcal meningitis vaccine indicating that the student has either been immunized within the preceding ten years or has opted not to obtain immunization against meningococcal disease.

Students may attach a signed medical form from their home school Health Center but it must include the MMR information and

Return this signed and completed form to:
 Syracuse University Abroad
 106 Walnut Place
 Syracuse, NY 13244-2650
 FAX: 315-443-4593

Please list exact dates (month, day, year) for all immunizations:

Immunization Dates

MMR 1st injection: _____/_____/_____

MMR 2nd injection: _____/_____/_____

Measles 1st injection: _____/_____/_____

Measles 2nd injection: _____/_____/_____

Rubella injection: _____/_____/_____

Mumps injection: _____/_____/_____

Disease Dates

Measles: _____/_____/_____

Meningitis

Those students wishing to reduce their risk of meningococcal disease should consider receiving the meningitis vaccine. The vaccine may be available at your home school Health Center. Further information about the disease and the benefits of the vaccine can be found at: http://students.syr.edu/dynamic/news.php?story_id=67.

I have elected the following option:

_____ Have been immunized within the preceding ten years.
 Date of immunization: _____/_____/_____

_____ Not to obtain meningitis vaccine.

 Signature of student Date

Serologic Evidence Dates

	Result (+ or -)
Measles titer: _____/_____/_____	_____
Rubella titer: _____/_____/_____	_____
Mumps titer: _____/_____/_____	_____

Tuberculin Information

PPD placed date: _____/_____/_____

PPD read date: _____/_____/_____

PPD result: _____ mm x _____ mm

Chest x-ray date: _____/_____/_____

Chest x-ray result: _____

Hepatitis B (optional)

The American College Health Association in conjunction with the Advisory Committee on Immunization Practices recommends that all college students receive Hepatitis B vaccine.

HepB 1st injection: _____/_____/_____

Hep B 2nd injection: _____/_____/_____

HepB 3rd injection: _____/_____/_____ or

Hepatitis B_s Antibody: _____/_____/_____

Other Immunization Dates

Tetanus: _____/_____/_____ Polio Completed: _____/_____/_____

HepA 1st injection: _____/_____/_____

HepA 2nd injection: _____/_____/_____

Varicella 1st injection: _____/_____/_____

Varicella 2nd injection: _____/_____/_____

Varicella Titer: _____/_____/_____ Result: _____

Varicella Disease: _____/_____/_____

I hereby attest to the accuracy of the information given:

HEALTH CARE PRACTITIONER'S SIGNATURE: _____ DATE: _____
 (This can be signed by a nurse, your family doctor, your college health center.)

ADDRESS: _____ PHONE: _____