TOURO COLLEGE
OFFICE OF THE REGISTRAR

2090 Adam Clayton Powell Jr. Blvd. – New York, New York 10027

Immunization Form

Students born on or after January 1, 1957 must provide a certificate of immunity (or immunization) to measles, mumps and rubella, such as: a laboratory copy of the results of MMR (positive) serology test, or an official health record documenting MMR immunity OR complete this form.

PERSONAL INFORMATION (To be completed by the student)

Name____ ____/____/____
First *Last* *Middle (complete)* *Date of Birth*

Social Security Number________________ Touro I.D. (if any) __________ Prog/Ext__________

MAILING ADDRESS

____
Number and Street *Apartment #* *City* *State* *Zip/Postal Code*

Phone (_____)________________ Email____________________________

TO BE COMPLETED AND SIGNED BY THE HEALTH PRACTITIONER ONLY

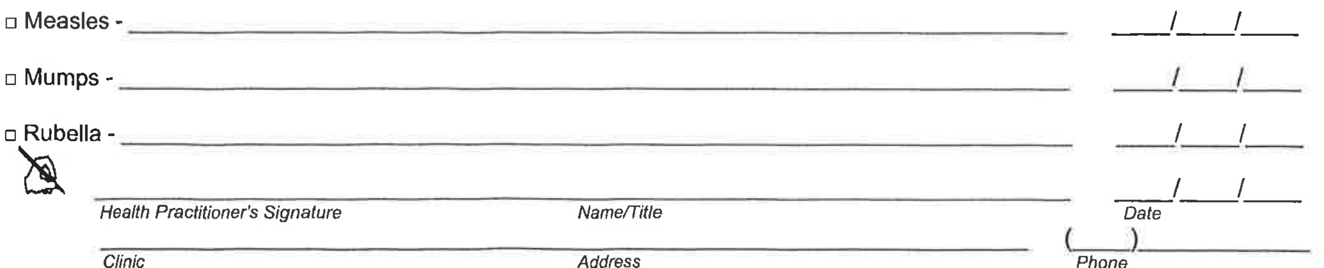
VACCINATION RECORD*

		Measles	Mumps	Rubella	or Combined MMR
Vaccination Date	**Dose 1**	__/__/__	__/__/__	__/__/__	__/__/__
(Two doses required for Measles or MMR)	**Dose 2**	__/__/__	__/__/__	__/__/__	__/__/__
Disease History (Date of Onset)		__/__/__	__/__/__	__/__/__	__/__/__
Serology Date and Results (Indicate + or-)		__/__/__	__/__/__	__/__/__	__/__/__
Include copy of lab report		______	______	______	______
Scheduled Date for Dose 2		__/__/__			__/__/__

Vaccination Guidelines: *MMR-First dose administered after the first birthday* ***and*** *after 1/1/1972. Measles-First Live Virus Dose Administered after first birthday and Second Live Virus Dose administered at least 28 days after the first dose. Mumps and Rubella-Live Virus Dose administered after first birthday* ***and*** *after 1/1/1969. Revaccination is required for MMR, measles, mumps and rubella if vaccinated prior to the stated dates.*

MEDICAL EXEMPTION FROM IMMUNIZATION

I certified that it is medically contraindicated for the above named person to be vaccinated for the disease(s) indicated below because of the stated medical reason. (Reason and expiration date—or state if permanent—required for each disease.)



Check diseases(s)-indicate medical reason(s) for contraindication **Valid through date**

□ Measles - ____________________________ ____/____/____

□ Mumps - ____________________________ ____/____/____

□ Rubella - ____________________________ ____/____/____

____________________________ ____/____/____
Health Practitioner's Signature *Name/Title* *Date*

____________________________ (____)________
Clinic *Address* *Phone*