IMMUNIZATION RECORD—STUDENT MUST SCAN & UPLOAD COMPLETED FORM TO SKIDMORE ONLINE HEALTH PORTAL

Student Name: _____ **Birth Date** *(mm/dd/yy):* ____/____/____

1. REQUIRED IMMUNIZATIONS

Date format MM/DD/YY

MMR (Measles, Mumps, & Rubella)—NYS Health Department Law • 1st dose required after 1st birthday and • 2nd dose required at least 28 days after 1st dose **OR**	**MMR #1:** ____/____/____ **MMR #2:** ____/____/____
IF MMR NOT GIVEN NYS Health Department Law requires the following: **MEASLES** • 1st dose required after 1st birthday **AND** • 2nd dose required at least 28 days after 1st dose **AND** **MUMPS** • 1 dose required after 1st birthday **AND** **RUBELLA** • 1 dose required after 1st birthday **OR** **IMMUNE TITER RESULTS FOR MEASLES, MUMPS, RUBELLA** • Attach lab reports	**Measles #1:** ____/____/____ **Measles #2:** ____/____/____ **Measles Titer:** ____/____/____ **Mumps #1:** ____/____/____ **Mumps Titer:** ____/____/____ **Rubella #1:** ____/____/____ **Rubella Titer:** ____/____/____
MENINGITIS—MENACTRA OR MENVEO (ACWY) • 1st dose over age 12 • 2nd dose over age 16 **OR** 1 dose within the last 5 years	**Meningitis #1:** ____/____/____ **Meningitis #2:** ____/____/____
TETANUS-DIPTHERIA-PERTUSSIS—Most recent booster TD or Tdap • Required within last 10 years	**TD :** ____/____/____ **Tdap:** ____/____/____

2. RECOMMENDED IMMUNIZATIONS

Date format MM/DD/YY

Meningococcal B: Bexsero **Men B #1:** ____/____/____ **Men B #2:** ____/____/____ **OR** **Meningococcal B: Trumenba** **Men B #1:** ____/____/____ **Men B #2:** ____/____/____ **Men B #3:** ____/____/____	**Hepatitis A #1:** ____/____/____ **Hepatitis A #2:** ____/____/____ **Hepatitis B #1:** ____/____/____ **Hepatitis B #2:** ____/____/____ **Hepatitis B #3:** ____/____/____
HPV (Human Papilloma Virus) **Gardasil #1:** ____/____/____ **Gardasil #2:** ____/____/____ **Gardasil #3:** ____/____/____	**Polio:** (circle one) **IPV OPV** **Primary series completed:** ____/____/____ **Additional dose post completion of primary series (if applicable):** ____/____/____
Varicella (Chickenpox) **Varicella #1:** ____/____/____ **Varicella #2:** ____/____/____ **OR** **History of Chickenpox: _____Yes _____ No**	**Other Immunizations** (most recent date) **Rabies** (date series completed) ____/____/____ **Typhoid** (injectable) ____/____/____ **Typhoid** (Oral) ____/____/____ **Yellow Fever** ____/____/____
STATEMENT OF EXEMPTION TO NEW YORK STATE IMMUNIZATION LAW ☐ **Religious Exemption:** Student or parent/guardian (if student is under the age of 18) adheres to a religious belief opposed to some/all immunizations and must submit statement according to policy on Health Services website. ☐ **Medical Exemption:** The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.	**PROVIDER INFORMATION & SIGNATURE REQUIRED** _____ **Name & Title of Healthcare Provider** (please print) _____ **Provider Signature** **Date** **Address** (print or stamp) _____ _____ _____ **Phone:** (_____) _____ **Fax:** (_____) _____