



SKIDMORE COLLEGE HEALTH SERVICES

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IMMUNIZATION RECORD

STUDENT NAME: _____ DATE OF BIRTH (mm/dd/yy): ____/____/____

REQUIRED IMMUNIZATIONS date format (mm/dd/yy)

MEASLES, MUMPS, RUBELLA REQUIREMENT –ONE of the following options - NYS Department of Health Law

OPTION 1: MMR (Measles, Mumps, & Rubella) combo vaccine

- 1st dose given no more than 4 days prior to 1st birthday and
• 2nd dose given at least 28 days after 1st dose

MMR #1: __/__/__

MMR #2: __/__/__

OPTION 2: Separate vaccines (4 in total)

Measles (2 doses)

- 1st dose given no more than 4 days prior to 1st birthday AND
• 2nd dose given at least 28 days after 1st dose AND

Measles #1: __/__/__

Measles #2: __/__/__

Mumps

- Single dose given no more than 4 days prior to 1st birthday AND

Mumps #1: __/__/__

Rubella

- Single dose given no more than 4 days prior to 1st birthday

Rubella #1: __/__/__

OPTION 3: Antibody titers for measles, mumps, rubella

- Attach lab reports

Measles Titer: __/__/__

Mumps Titer: __/__/__

Rubella Titer: __/__/__

MENINGITIS – ACWY (Menactra, MenQuadfi, Menveo) OR ABCWY (Penbraya, Penmenvy)

- At minimum 1 dose within 5 years of the first day of classes
*Men B alone does not meet this requirement

Meningitis: __/__/__

TETANUS-DIPHTHERIA-PERTUSSIS— Td or Tdap Required within 10 years of the first day of classes

Td : __/__/__

Tdap: __/__/__

RECOMMENDED IMMUNIZATIONS date format (mm/dd/yy)

Table with 4 columns: MENINGOCOCCAL B, Hepatitis A/B, HPV, and POLIO. Each column contains vaccination options and dates.

OTHER IMMUNIZATION (most recent date)

Rabies (date series completed) __/__/__ Typhoid (Oral) __/__/__
Yellow Fever __/__/__ Typhoid (Inj) __/__/__

VARICELLA (Chickenpox)

Varicella #1: __/__/__ History of disease:
Varicella #2: __/__/__ OR Date: _____

STATEMENT OF EXEMPTION TO NEW YORK STATE IMMUNIZATION LAW

- Religious Exemption
Medical Exemption

Required supporting documentation must be provided as specified on the Health Services website:

https://www.skidmore.edu/health-services/policies/ImmunizationRequirementsandExemption.php

PROVIDER INFORMATION & SIGNATURE REQUIRED

Name & Title of Healthcare Provider (please print)

Provider Signature Date

Address (print or stamp)

Phone: (____) _____ Fax: (____) _____