Schenectady County Community College
Student Affairs, Elston Hall 222
78 Washington Avenue
Schenectady, New York 12305

STUDENT IMMUNIZATION RECORD FORM

All students enrolled in six (6) credit hours or more, whose birth date is on or after January 1, 1957, MUST comply with immunization requirements. Immunization information must be received by Student Affairs, Elston Hall 222 in person, by mail to the above address, by fax to: 518-381-1456 or sent via email to immunizations@sunysccc.edu before the student attends the first class. Please call 518-381-1344 with questions.

Name_____________________________________ Date of Birth _______________ Student ID____________________

Semester___________ Year_________ Phone Number_________________ Email ______________________________

Required: Two doses of the **MMR** immunization, given after 12 months of age with the second dose at least one month after the first dose **or** blood tests showing immunity to all three illnesses.

Measles (Rubeola) Two doses required: Vaccine Date __________________Vaccine Date____________________

Mumps Vaccine Date _______________ or Disease History____

Rubella Vaccine Date _______________ or Disease History____

or

Titer – Results from this test are useful for people who are not sure if they have been vaccinated or need to prove if they have immunity from prior vaccinations.

Measles (Rubeola) Titer Date __________________ Result____

Mumps Titer Date __________________ Result ____

Rubella Titer Date __________________ Result ____

Required: One dose of the Meningococcal immunization given within the last 5 years; **or** a complete two dose series **or** a signed waiver. New York State Department of Health requires each student to indicate meningitis compliance by providing a waiver of the vaccine OR providing medical documentation of date of vaccine.

Meningococcal Vaccine for Meningitis Vaccine Date __________________Vaccine Date____________________

or

WAIVER: I have reviewed the information regarding meningococcal disease. I am fully aware of the risks associated with this disease and of the availability and effectiveness of the vaccine. I have elected NOT to get the vaccine.

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Signature of Student (Parent/Guardian if student is under 18) Date

EARLY CHILDHOOD STUDENTS ONLY: Tuberculin Date________________ Send result attached to college physical.

Physician Comments____

Physician Name (Printed)____________________________Signature___________________________Date__________

Address and Phone number:____

We accept proof of immunizations from medical offices, schools and universities. If you are providing an immunization report from your doctor's office, school or university, it is not necessary to have this form signed or to return this form as long as you have met the MMR and Meningitis requirement.