



CERTIFICATE OF IMMUNIZATION FOR INTERNATIONAL STUDENTS

All Students MUST provide the following vaccination and health history information. Please have your health care provider complete this form OR you can upload an official copy (signed/stamped by your health care provider or prior school.) Register for the **Student Health Patient Portal**, upload this completed form and necessary documents, and complete your **Health History** located under **Required Forms** at <https://oneonta.medicatconnect.com/> prior to arriving at SUNY Oneonta. **Forms are due by Dec. 30th for Spring enrollment, June 1st for Fall enrollment, and April 30th for summer enrollment.**

Student Name: _____ **Student A#** _____

Date of Birth: _____ (MM/DD/YY) **Home Phone:** _____ **Cell Phone:** _____

Home Address: _____ **Country:** _____

REQUIRED IMMUNIZATIONS

❖ Measles/Mumps/Rubella (MMR)

MMR dose #1 (on or after first birthday) _____ (MM/DD/YY)

MMR dose #2 (at least 28 days after 1st dose) _____ (MM/DD/YY)

❖ **In absence of proof of MMR vaccination, the following must be provided:**

Measles Dose #1 (on or after first birthday) _____ (MM/DD/YY)

Measles Dose #2 (at least 28 days after first) _____ (MM/DD/YY)

Mumps #1 _____ (MM/DD/YY)

Rubella #1 (1 dose on or after first birthday) _____ (MM/DD/YY)

❖ **OR Serologic evidence of immunity for Measles, Mumps, and/or Rubella (blood test, serology) confirming immunity- Please attach and/or UPLOAD LAB RESULTS**

❖ Meningococcal Meningitis Vaccine Response - [Meningococcal Disease Fact Sheet \(ny.gov\)](#).

Must either report date of immunization within the past 5 years or Sign declination, to be COMPLETED and SIGNED by student or parent/guardian for student under the age of 18. Information regarding this requirement may be found at [Section I - Requirements \(ny.gov\)](#) Please check the appropriate box and sign below.

☐ I received the MCV4 (A,C,Y,W-135) vaccine within the past 5 years: (mm/dd/yy) _____

☐ I completed another meningococcal vaccine series within the past 5 years: (mm/dd/yy): _____

☐ I understand the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (or my child) will NOT obtain immunization against meningococcal meningitis.

❖ Tuberculosis Screening/Testing Information

Please provide ONE of the following: PPD (Mantoux testing) must be resulted in mm and completed no earlier than 6 months prior to semester start if you are from a high-burden country for TB. List of high burden countries.

PPD Date given: _____ (mm/dd/yy) **PPD Date read:** _____ (mm/dd/yy) **PPD results in mm:** _____

If POSITIVE - Upload copy of radiology chest x-ray report and any treatment regimen for latent/active tuberculosis.

OR T-spot bloodwork completed no earlier than 6 months prior to semester start. **Lab Result Must Be Attached.** If POSITIVE, upload a copy of chest x-ray report and any treatment regimen for latent/active tuberculosis.

Student Signature or guardian signature if under age 18: _____ **Date:** _____



RECOMMENDED IMMUNIZATIONS

❖ Hepatitis B Vaccine Series (MM/DD/YY)

Hepatitis B #1: _____ Hepatitis B #2: _____ Hepatitis B #3: _____

❖ Tetanus-Diphtheria and Pertussis (within last 10 years):

Td _____ (MM/DD/YY) or Tdap _____ (MM/DD/YY)

❖ COVID – 19 Vaccine (OPTIONAL *This is no longer a requirement*)

Please complete below by health care provider OR upload a copy of your CDC vaccination card to the Student Health Patient Portal.

Manufacturer _____ Dose #1 Date: _____ (MM/DD/YY)

(if applicable) Dose #2 Date: _____ (MM/DD/YY)

(if applicable) Booster Date: _____ (MM/DD/YY)

Student's emergency contact information:

Emergency contact name: _____

Relationship to student: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

THIS FORM MUST BE SIGNED BELOW BY A HEALTH CARE PROVIDER TO CERTIFY ITS ACCURACY.

Signature: _____ Date: _____

Printed name: _____ Phone: _____ Fax: _____

Address: _____