Proof of Immunization Form: Domestic 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. 30 for Spring enrollment, June 30 for Fall enrollment, and April 30 for summer enrollment.**

Student Name _____ **Student ID#** _____

Date of Birth _____**(mm/dd/yyyy) Home Phone**_____ **Cell Phone** _____

Home Address _____

REQUIRED IMMUNIZATIONS

- **Measles/Mumps/Rubella (MMR)**

  MMR# 1:(on or after first birthday) _____(mm/dd/yy) | MMR#2:(at least 28 days after1st 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) | Dose #2 (at least 28 days after first)_____(mm/dd/yy)

  Mumps (1 dose on or after first birthday) #1_____(mm/dd/yy)

  Rubella (1 dose on or after first birthday) #1_____(mm/dd/yy)

  OR Serologic evidence of immunity for Measles, Mumps, and/or Rubella. Uploaded laboratory required for verifying immunity.

- **COVID – 19:** completed below by health care provider **OR** upload a copy of your CDC vaccination card to the Student Health Patient Portal. To satisfy this requirement, you must be **fully vaccinated** (two weeks past the final dose required for the manufacturer of your vaccine)

  Manufacturer_____ Dose #1 Date: _____ (mm/dd/yy)

  (if applicable) Dose #2 Date: _____ (mm/dd/yy)

  (if applicable) Booster Date: _____ (mm/dd/yy)

- **Meningococcal Meningitis Vaccine Response**
  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 www.health.ny.gov/publications/2168.pdf . Please check the appropriate box and sign below.

  - ☐ I have received the meningococcal ACWY vaccine within the past 5 years on date: _____(mm/dd/yy)
  - ☐ I have read or have had explained to me the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal meningitis.

Student please sign below (guardian signature required if student is under the age of 18)

Signature X _____ **Date:** _____

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

Signature:_____ **Date:** _____

Printed Name: _____ **Phone:**_____ **Fax:**_____

Address:_____

RECOMMENDED IMMUNIZATIONS **(also certified by medical provider)**

- **Hepatitis B Vaccine Series (mm/dd/yy):**

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

- **Tetanus/Diphtheria Booster (within last 10 years):**

  Td _____(mm/dd/yy) OR Tdap _____(mm/dd/yy)

- **Human Papilloma Virus (mm/dd/yy):**

  HPV #1: _____ HPV #2: _____ HPV #3: _____

Student's emergency contact information:

Emergency contact name: _____

Relationship to student: _____

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