Proof of Immunization Form: 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. 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 Address _____

Country _____ **Cell Phone** _____

Emergency Contact _____ **Relationship to student** _____

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

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:

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

   (1 dose at least 28 days after first dose) #2_____(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

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

❖ **COVID – 19 Vaccination:** 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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❖ **Tuberculosis Screening/Testing Information**

Please provide ONE of the following

1. PPD (Mantoux testing) must be resulted in mm and completed no earlier than 6 months prior to semester start.

   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

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

RECOMMENDED IMMUNIZATIONS

❖ **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)

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

Signature X: _____ _____Date: _____

Printed name: _____ Phone: _____Fax:_____

Address: _____