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 Address ____**Home Phone**_________________ **Cell Phone** _____________________

REQUIRED IMMUNIZATIONS

- **Measles/Mumps/Rubella (MMR)** **(Dose one on or after 1st birthday, dose two at least 28 days after 1st dose)**

  MMR# 1: _______________________(mm/dd/yy) MMR#2: _____________________(mm/dd/yy)

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

  Measles #1________________________ (mm/dd/yy) #2_________________________(mm/dd/yy)

  Mumps #1_____________________(mm/dd/yy) Rubella #1_____________________(mm/dd/yy)

  OR 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) Dose #2 Date: _________________ (mm/dd/yy)

- **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 have received the meningococcal ACWY vaccine within the past 5 years on date: ________________(mm/dd/yy)
  ☐ I have completed the MenB vaccine 2-3 dose series 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:** ________________________

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: ___________________________