# 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)** (1 dose on or after 1st birthday, 1 dose 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: (1 dose on or after first birthday for the following vaccines)

  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** (defined as two weeks past the final dose)

  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.

**Signature (student or guardian if under age 18):** _____ **Date:** _____

- **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.
  **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 copy of chest x-ray report and any treatment regimen for latent/active tuberculosis.

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

**Signature X:** _____ **Date:** _____

**Printed name:** _____ **Phone:** _____**Fax:**_____

**Address:** _____

**Form continued on back**

## 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)