Proof of Immunization Form for International Students

*Please mail form back to **SUNY Oneonta Student Health Services; 108 Ravine Parkway, Oneonta NY, 13820 USA** or Email/Scan a copy to **healthcenter@oneonta.edu** by June 30th for new Fall students and by December 30th for new Spring students.*

All students MUST provide proof of immunity against measles, mumps, and rubella. Individuals born prior to January 1, 1957 are exempt from this immunization requirement, but the rest of the health requirements must be met. You must have your health care provider complete this form in your home country. You must also register for the **Student Health Portal** and complete your **Health History** located under **Required Forms** at https://patient-oneonta.medicatconnect.com/ **prior to arriving** at SUNY Oneonta.

Student Name_____

Student ID# _____

Home Address _____

_____**Country**_____

Cell Phone _____

Birth Date ___ ___ - ___ ___ - ___ ___ ___ ___

REQUIRED IMMUNIZATIONS

Options for Proof of Measles/Mumps/Rubella (MMR):

MMR #1:_____(mm/dd/yy)

MMR #2:_____(mm/dd/yy)

OR

Measles Titer*: _____(mm/dd/yy)

Mumps Titer *: _____(mm/dd/yy)

Rubella Titer*: _____(mm/dd/yy)

*attach copy of titer reports to this form

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

Signed X_____Date:_____

Required Signature and Title of Healthcare Provider

Printed Name _____

Address_____

_____

Phone/Fax Number_____

RECOMMENDED IMMUNIZATIONS

Hepatitis B Vaccine series:
Hepatitis B #1: _____(mm/dd/yy)
Hepatitis B #2: _____(mm/dd/yy)
Hepatitis B #3: _____(mm/dd/yy)

Tetanus/Diphtheria Booster (within last 10 years):
□ Td _____(mm/dd/yy)
□ Tdap _____(mm/dd/yy)

Emergency Contact

Name _____Relationship_____

Home Phone _____

Cell Phone _____Business Phone_____

MENINGOCOCCAL MENINGITIS VACCINE RESPONSE
☆Must Either Report Date of Immunization or Sign Declination, to be COMPLETED and SIGNED by student or parent/guardian for student under the age of 18

(The Advisory Committee on Immunization Practices recommends that all first – year college students up to age 21 should have at least 1 dose of Meningococcal vaccine not more than 5 years before enrollment, preferably on/after their 16th birthday)

□ I have received the meningococcal vaccine Date: _____

□ I have read, or have had explained to me, the information regarding meningococcal meningitis disease
http://www.oneonta.edu/development/health/meningitis.asp

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

Signed X_____ Date: _____

Student Signature or Parent Signature (if under 18)

TUBERCULOSIS SCREENING/TESTING INFORMATION

BCG Immunization Date:_____ (mm/dd/yy)

PPD (Mantoux testing) must be resulted in mm and completed no earlier than 6 months prior to semester start.
(results should read i.e. 00mm for a negative PPD result)

Date of PPD given:_____ (mm/dd/yy)

Date of PPD read:_____(mm/dd/yy)

PPD results in mm _____

If positive please attach a copy of a radiology report of chest x-ray and any treatment regimen for latent/active tuberculosis.