COLLEGE OF
MOUNT SAINT VINCENT
HEALTH CENTER
6301 Riverdale Avenue, Riverdale NY 10471
Phone: 718.405.3240 FAX: 718.405.3737

Student's Name:_____ Date of Birth: _____/_____/_____

Cell Phone: # _____ CMSV ID: # _____

I. REQUIRED MEASLES, MUMPS & RUBELLA (MMR) Proof of Immunity for ALL Students born on or after 1/01/57

To be completed and signed by Health Care Provider – a previous immunization record may be attached

Section A. MMR (Measles, Mumps, Rubella; was not available in the US before 1/1/72) **Month Day Year**

_____ 1st MMR Vaccine - Administered after 1st birthday and after 1/1/72 _____/_____/_____

AND

_____ 2nd MMR Vaccine given after 15 months of age and at least 28 days after 1st MMR _____/_____/_____

Section B1. Measles **Month Day Year**

_____ 1st Live Virus Vaccine – Administered after 1st birthday and 1/1/68 _____/_____/_____

AND

_____ 2nd Live Virus Vaccine –after 15 months of age and at least 28 days after 1st Vaccine _____/_____/_____

OR

_____ Immunity – Proven by Serologic Testing (Attach Lab Slip) _____/_____/_____

Section B2. Mumps **Month Day Year**

_____ Live Virus Vaccine – Administered after 1st birthday and 1/1/69 _____/_____/_____

OR

_____ Immunity – Proven by Serologic Testing (Attach Lab Slip) _____/_____/_____

Section B3. Rubella (German Measles) **Month Day Year**

_____ Live Virus Vaccine - Administered after 1st birthday and 1/1/69 _____/_____/_____

OR

_____ Immunity – Proven by Serologic Testing (Attach Lab Slip) _____/_____/_____

MD or NP Signature:_____ **State / License # _____**

II. MENINGITIS REQUIREMENT for ALL Students – Form must be completed and signed.

Read the Meningitis Information on the college web-site and complete this form and sign below.

Commuter Students: If the Meningitis Vaccine has not been received, sign the waiver below

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 **or** my child (if he/she is under the age of 18) will **not** obtain immunization against Meningococcal Meningitis disease.

Name:_____ **Signature:**_____ **Date:**_____

Resident Students: You must document that you have received the Meningitis Vaccine to live in the Dorm.
If you are a Commuter who has received the Meningitis Vaccine, document it below.

_____**Menomune:** _____**Menactra:** _____**Menveo:** **Date Received** _____/_____/_____

Name:_____ **Signature:**_____ **Date:**_____

MD or NP Signature:_____ **MD or NP (print name)**_____

Address:_____

(use office stamp)

Rev. 1/2014