LANDER COLLEGE FOR WOMEN
THE ANNA RUTH AND MARK HASTEN SCHOOL

A Division of Touro College

Immunization Form

Submit or mail to: Office of the Registrar, 227 West 60th Street, New York, NY 10023

Students born on or after January 1, 1957 must provide a certificate of immunity (or immunization) to measles, mumps and rubella, such as: a laboratory copy of the results of MMR (positive) serology test, or an official health record documenting MMR immunity OR complete this form.

PERSONAL INFORMATION (To be completed by the student)

Name_____ _____/_____/_____
First Last Middle (complete) Date of Birth

Social Security Number_____ Touro I.D. (if any) _____ Prog/Ext_____

MAILING ADDRESS

_____
Number and Street Apartment # City State Zip/Postal Code

Phone (_____)_____ Email_____

TO BE COMPLETED AND SIGNED BY THE HEALTH PRACTITIONER ONLY

VACCINATION RECORD*

		Measles	Mumps	Rubella	or Combined MMR
Vaccination Date	**Dose 1**	____/____/____	____/____/____	____/____/____	____/____/____
(Two doses required for Measles or MMR)	**Dose 2**	____/____/____	____/____/____	____/____/____	____/____/____
Disease History (Date of Onset)		____/____/____	____/____/____	____/____/____	____/____/____
Serology Date and Results (Indicate + or-)		____/____/____	____/____/____	____/____/____	____/____/____
Include copy of lab report		_____	_____	_____	_____
Scheduled Date for Dose 2		____/____/____			____/____/____

***Vaccination Guidelines:** MMR-First dose administered after the first birthday **and** after 1/1/1972. Measles-First Live Virus Dose Administered after first birthday and Second Live Virus Dose administered at least 28 days after the first dose. Mumps and Rubella-Live Virus Dose administered after first birthday **and** after 1/1/1969. Revaccination is required for MMR, measles, mumps and rubella if vaccinated prior to the stated dates.*

MEDICAL EXEMPTION FROM IMMUNIZATION

I certified that it is medically contraindicated for the above named person to be vaccinated for the disease(s) indicated below because of the stated medical reason. (Reason and expiration date—or state if permanent—required for each disease.)

Check diseases(s)-indicate medical reason(s) for contraindication **Valid through date**

□ Measles - _____ ____/____/____

□ Mumps - _____ ____/____/____

□ Rubella - _____ ____/____/____

_____ ____/____/____
Health Practitioner's Signature Name/Title Date

_____ (____)_____
Clinic Address Phone