



TOURO COLLEGE & UNIVERSITY SYSTEM Registrar's Office

Immunization Form

This form is to be completed by all students born on or after January 1, 1957.

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 _____

Day Phone (_____) _____ Evening Phone (_____) _____

Check at least one of the statements below.

- Vaccination Record below is complete for each disease. I have no acceptable alternate record or exemptions to submit.
- Alternate records are attached for each disease.
- Medical Exemption on reverse is complete for each vaccination for which I claim medical examination.
- Religious exemption is attached for all diseases.

Signature _____

Date _____

Vaccination record (To be completed by the health practitioner)

	Measles	Rubella	Mumps	or Combined MMR
Vaccination Date				
Dose 1	____/____/____	____/____/____	____/____/____	____/____/____
Does 2	____/____/____	____/____/____	____/____/____	____/____/____
Disease history <small>(Date of Onset)</small>	____/____/____	____/____/____	____/____/____	____/____/____
____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Serology Date and Results <small>(Indicate + or -) Include copy of lab report</small>	____/____/____	____/____/____	____/____/____	____/____/____
____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Scheduled Date for Dose 2	____/____/____	____/____/____	____/____/____	____/____/____

Important Note About Revaccination:

Measles—If administered prior to 1968 and not specified as “live” and/or if student was less than 12 months of age for first dose and/or less than 15 months of age for second dose, vaccination must be repeated. Indicate date for follow-up. Mumps and Rubella—If vaccination was given prior to 1969 and/or if patient was less than 12 months of age, vaccination must be repeated.

I certify that the above information is correct. (Must be signed by health practitioner)

Signature _____

Name / Title _____

Date _____

Clinic _____

Address _____

Phone (_____) _____



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Exemptions

Students registered exclusively in courses coded as online are exempt.

Medical Exemption from Immunization (To be completed by the health practitioner)

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

Check disease(s)—indicate medical reason(s) for contraindication

Valid through date

- Measles — _____ / ____ / ____
- Mumps — _____ / ____ / ____
- Rubella — _____ / ____ / ____

Must be signed by health practitioner to be acceptable.

Signature	Name/Title	Date / ____ / ____
Clinic	Address	(____) _____

Religious Exemption from Immunization

You must provide the college with a signed statement that describes in sufficient detail that your beliefs are

1. religious in nature, not philosophical and
2. your beliefs are sincerely and genuinely held.

Statements must include the name of the religious affiliation.