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.

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

_____/_____/_____
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 *(Date of Onset)*		_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
		_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Serology Date and Results *(Indicate + or –) Include copy of lab report*		_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
		_____	_____	_____	_____
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* *Phone*