SUNY ONEONTA

CERTIFICATE OF IMMUNIZATION FORM (DOMESTIC STUDENTS)

All Students MUST provide the following vaccination and health history information. Please have your health care provider complete this form OR you can upload an official copy (signed/stamped by your health care provider or prior school.) Register for the **Student Health Patient Portal, upload this completed form and necessary documents,** and complete your **Health History** located under **Required Forms** at https://oneonta.medicatconnect.com/ **prior to arriving** at SUNY Oneonta. **Forms are due by Dec. 30 for Spring enrollment, June 30 for Fall enrollment, and April 30 for summer enrollment.**

Student Name:_____ **Student ID#** _____

Date of Birth: _____**(MM/DD/YY) Home Phone:** _____**Cell Phone:** _____

Home Address: _____

REQUIRED IMMUNIZATIONS

- **Measles/Mumps/Rubella (MMR)**

MMR dose #1 (on or after first birthday) _____(MM/DD/YY)

MMR dose #2 (at least 28 days after1st dose) _____(MM/DD/YY)

- ***In absence of proof of MMR vaccination, the following must be provided:***

Measles Dose #1 (on or after first birthday) _____(MM/DD/YY)

Measles Dose #2 (at least 28 days after first) _____(MM/DD/YY)

Mumps #1 _____ (MM/DD/YY)

Rubella #1 (1 dose on or after first birthday) _____(MM/DD/YY)

- **OR** *Serologic evidence of immunity for Measles, Mumps, and/or Rubella (blood test, serology) confirming immunity- Please attach and/or UPLOAD LAB RESULTS*

- **Meningococcal Meningitis Vaccine Response -** Meningococcal Disease Fact Sheet (ny.gov).

Must either report date of immunization within the past 5 years or Sign declination, to be COMPLETED and SIGNED by student or parent/guardian for student under the age of 18. Information regarding this requirement may be found at Section I - Requirements (ny.gov) Please check the appropriate box and sign below.

☐ I received the MCV4 (A,C,Y,W-135) vaccine within the past 5 years on date: _____ I completed another meningococcal vaccine series within the past 5 years on date: _____

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

Student Signature or guardian signature if under age 18: _____ Date: _____

RECOMMENDED IMMUNIZATIONS (also certified by medical provider)

- **Hepatitis B Vaccine Series (MM/DD/YY):**

  Hepatitis B #1: _____ Hepatitis B #2: _____ Hepatitis B #3: _____

- **Tetanus/Diphtheria Booster (within last 10 years):**

  Td _____(MM/DD/YY) OR Tdap _____(mm/dd/yy)

- **Human Papilloma Virus (MM/DD/YY):**

  HPV #1: _____ HPV #2: _____ HPV #3: _____

- **COVID – 19 Vaccine (OPTIONAL *This is no longer a requirement)***

  Please complete below by health care provider **OR** upload a copy of your CDC vaccination card to the Student Health Patient Portal.

  Manufacturer _____ Dose #1 Date: _____(MM/DD/YY)

  (if applicable) Dose #2 Date: _____(MM/DD/YY)

  (if applicable) Booster Date: _____(MM/DD/YY)

Student's emergency contact information:

Emergency contact name: _____

Relationship to student: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

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

Signature:_____ **Date:** _____

Printed Name: _____ **Phone:**_____ **Fax:**_____

Address:_____