NORTH COUNTRY COMMUNITY COLLEGE

MMR Immunization Validation Form

Name: ______________________________ Other Names Used: ______________________

Address: ____ Date of Birth ____________

NY State Public Health Law 2165 requires all post-secondary students born on or after January 1, 1957, and enrolled in six or more credit hours, to provide proof of immunity to measles, mumps, and rubella. Appropriate documentation must include ONE of the following:

- Documentation of TWO (2) MMR vaccinations. To be considered valid, the first vaccination cannot be administered any more than four days prior to the student's first birthday, and the second dose must be given at least 28 days after the first dose.
- Documentation of TWO (2) doses of the measles vaccination, ONE (1) dose of the mumps vaccination, and ONE (1) dose of the rubella vaccination. To be considered valid, neither vaccination can be administered any more than four days prior to the student's first birthday, and the SECOND dose of the measles vaccination must be given at least 28 days after the first dose.
- POSITIVE blood titer results for measles, mumps, and rubella. Copies of a lab report(s) validating these results must be submitted.

To assist with documenting one of the above options, you may choose to have your health care provider complete this form. Please note that, if you are able to obtain a copy of your immunization record from another source (high school, another college, etc.), it is NOT necessary to complete this form. However, it is necessary to submit the "Meningococcal Disease Response Form" contained in this packet.

To be completed by a health care provider, NOT the student or student's parent/guardian

OPTION 1	**OPTION 2**
Date of MMR #1 __________	Date of **POSITIVE** Blood Titers
Date of MMR #2 __________	*A copy of lab report must be attached to verify results.*
OR	
Date of Measles #1 __________	+ Measles Blood Titer Date __________
Date of Measles #2 __________	
Date of Mumps #1 __________	+ Mumps Blood Titer Date __________
Date of Rubella #1 __________	+ Rubella Blood Titer Date __________

The above vaccination(s) have been validated by:

Health Care Provider name (printed) ______________________ Telephone Number

Address ____________________________________ ____________________

Street City State Zip

HCP's Signature ______________________________

The medical office's stamp validating this information can be used in lieu of the provider's signature.

Date ____________________

SLO: Fall 2019