Na
Measles, mumps and rubella (MMR)

CONTINUING STUDIES

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Measles/Mumps/Rubella (MMR).
Please provide one of the following types of immunization documentation for each column, checking the appropriate box:

<table>
<thead>
<tr>
<th>Measles, mumps and rubella (MMR)</th>
<th>Meningitis</th>
<th>Chicken pox (Varicella)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of immunization series:</td>
<td>Signed letter from the student's physician, or a copy of the student's medical record, indicating that the student has met State of Connecticut immunization series criteria for higher education, including the dates of the doses</td>
<td>Documentation of immunization series</td>
</tr>
<tr>
<td>2 doses of MMR vaccine</td>
<td>Separated by at least 28 days</td>
<td>2 doses of varicella vaccine</td>
</tr>
<tr>
<td>Separated by at least 28 days</td>
<td>First dose on or after 1st birthday</td>
<td>Separated by at least 28 days</td>
</tr>
<tr>
<td>First dose on or after 1st birthday</td>
<td></td>
<td>First dose on or after 1st birthday</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation of laboratory confirmation of immunization</th>
<th></th>
<th>Documentation of laboratory confirmation of immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician's note stating that, in the physician's opinion, immunization is contra-indicated and the specific reason for the opinion</td>
<td>Documentation that you have had the disease</td>
<td></td>
</tr>
<tr>
<td>Please note that in October 2010 the Advisory Committee on Immunization Practices is now recommending booster doses of the MCV4 vaccine for healthy adolescents 16-18 years of age. If it has been greater than 5 years since your last immunization, please speak to your medical provider about getting a booster shot.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation from physician that you are medically contraindicated from receiving these vaccines</th>
<th>Signed affidavit by the student stating immunization is contrary to the student's religious beliefs</th>
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</tr>
</thead>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Student signature: __________________________ Date: __________________________

This cover sheet and the immunization documentation should be delivered by mail, hand-delivery or fax to:

University Health Services
327 High Street
Middletown, CT 06459 fax
860.685.2471

STUDENT HEALTH SERVICES USE ONLY

Student immunization documentation is:

__ Complete __ Incomplete

__ Blood test __ Vaccination record incomplete

__ Contra-indicated by physician note __ Missing lab work

__ Religious exemption __ Other

Reviewer’s signature and date: ____________________________________________________________

CONTINUING STUDIES OFFICE USE ONLY

Student Records
Processed by: (initials and date)