

ROCKLAND COMMUNITY COLLEGE

Immunization Form

REQUIRED OF ALL STUDENTS ENROLLING FOR 6 OR MORE CREDITS

Submit this form and any required documentation (NOT ORIGINALS) to The Registrar's Office, 145 College Road, Suffern, NY 10901 or fax to (845) 574-4499. Please Print:

Name: Last _____ First _____ M.I.-Maiden _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Local Phone: (_____) _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____

PART I: Meningococcal Meningitis

For all students regardless of age, NYS Public Health Law mandates that you read and sign PART I. **Meningitis disease** is a severe bacterial infection of the bloodstream or meninges (a thin layer covering the brain and spinal cord). It is a relatively rare disease and usually occurs as a single isolated event. Clusters of cases or outbreaks are rare in the United States. It is transmitted through the air via droplets of respiratory secretions and direct contact with an infected person. Direct contact, for these purposes, is defined as oral contact with shared items such as cigarettes or drinking glasses or through intimate contact such as kissing. Although anyone can come in contact with the bacteria that causes meningococcal disease, data also indicates certain social behaviors, such as exposure to passive and active smoking, bar patronage, and excessive alcohol consumption, may put students at increased risk for the disease.

For more information please log on to our website at
www.sunyrockland.edu/regist/immuniz.htm

You may also contact your health care provider or the
Rockland County Health Department (845) 364-2520 for more
information about the Meningitis disease or vaccination information.

PART I: Meningococcal Meningitis RESPONSE

To be completed & signed by student or parent/guardian for students under age 18.

- I have read the information regarding meningococcal meningitis disease and I understand the risk of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signature _____

Date _____

PART II: Measles, Mumps & Rubella

For all students born on /after 1/1/57, NYS Public Health Law mandates that you provide signed documentation of proof of immunity against measles, mumps & rubella on/after the first birthday. Students must submit proof of compliance with the law within thirty days of the start of the semester **OR THEY WILL BE WITHDRAWN, WITHOUT REFUND, FROM ALL CLASSES.**

MEASLES - Immunization (2 injections) on or after 1/1/68 (at least thirty days apart) OR positive titer OR date of physician documented disease.

Note: Immunizations before 1/1/68 are acceptable if there is proof that live vaccine was used.

MUMPS - Immunization (1 injection) on or after 1/1/69 OR positive titer OR physician documented disease.

RUBELLA - Immunization (1 injection) on or after 1/1/69 OR positive titer. (Proof of disease not acceptable.)

You may provide any health records which demonstrate proof of immunity from prior schools, physicians or a local health department. You can also be immunized by your doctor or health care provider or you can call the county health department for free immunization (845) 364-2520. Bring proof of this first measles shot and an appointment card for the second prior to or at registration.

If you hold religious beliefs which prohibit receiving immunizations for Measles, Mumps & Rubella, contact the **Records Office at (845) 574-4030.**

HEALTH CARE PROVIDER STAMP IS REQUIRED FOR PART II:

PART II: PROOF OF Measles, Mumps & Rubella IMMUNITY

MUST be completed and stamped by a Health Care Provider.

MMR (MEASLES, MUMPS & RUBELLA combined vaccine)

Two Doses Required:

- Dose 1 - Must have been given on or after first birthday
Date received: mo _____ /day _____ /yr _____
- Dose 2 - Must have been given at least 30 days after Dose 1
Date received: mo _____ /day _____ /yr _____

OR if Measles, Mumps & Rubella given as individual vaccines:

MEASLES (check one box below if applicable):

- Positive immune titer Serology Date _____ results _____
- Date had disease OR
- Date of Dose 1: Immunized with live Measles vaccine
on/after Jan. 1, 1968 and on/or after first birthday
Date received: mo _____ /day _____ /yr _____
- If vaccinated prior to Jan. 1, 1968, I certify live vaccine was used.
Physician's Signature: _____

- Date of Dose 2: Live Measles vaccine must be given at least 30 days after Dose 1.
Date received: mo _____ /day _____ /yr _____

and MUMPS (check one box below):

- Positive immune titer Serology Date _____ results _____
- Date had disease OR
- Date of live vaccine on/after 1/1/69 & on/after 1st birthday
Date received: mo _____ /day _____ /yr _____

and RUBELLA (check one box below):

- Positive immune titer Serology Date _____ results _____
- Date of live vaccine on/after 1/1/69 & on/after 1st birthday
Date received: mo _____ /day _____ /yr _____

MENINGOCOCCAL MENINGITIS

- I (my Child) had the meningococcal meningitis immunization (Menomune™) within the last 10 years.
Date received: mo _____ /day _____ /yr _____