SUNY ONEONTA

CERTIFICATE OF IMMUNIZATION FOR INTERNATIONAL 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: ____ **Country:** _____________________

REQUIRED IMMUNIZATIONS

❖ **Measles/Mumps/Rubella (MMR)**

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

MMR dose #2 (at least 28 days after 1st 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: (mm/dd/yy) _______________

☐ I completed another meningococcal vaccine series within the past 5 years:(mm/dd/yy): ___________

☐ 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.

❖ **Tuberculosis Screening/Testing Information**

Please provide ONE of the following: PPD (Mantoux testing) must be resulted in mm and completed no earlier than 6 months prior to semester start if you are from a high-burden country for TB. See comprehensive list on page 48 of the Global tuberculosis report 2023

PPD Date given: ___________(mm/dd/yy) **PPD Date read**: ___________(mm/dd/yy) **PPD results in mm:** _____

If POSITIVE - Upload copy of radiology chest x-ray report and any treatment regimen for latent/active tuberculosis.

OR T-spot bloodwork completed no earlier than 6 months prior to semester start. **Lab Result Must Be Attached.** If POSITIVE, upload a copy of chest x-ray report and any treatment regimen for latent/active tuberculosis.

Student Signature or guardian signature if under age 18: ______________________ Date: _________________

RECOMMENDED IMMUNIZATIONS

- **<u>Hepatitis B Vaccine Series</u> (MM/DD/YY)**

  Hepatitis B #1: __________ Hepatitis B #2: __________________Hepatitis B #3: ________________

- **<u>Tetanus-Diphtheria and Pertussis</u> (within last 10 years):**

  Td ___________________(MM/DD/YY) or Tdap ______________________(MM/DD/YY)

- **<u>COVID – 19 Vaccine</u>** *(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)

<u>Student's emergency contact information:</u>

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: ____