Brooklyn College • Division of Student Affairs • Health Programs and Immunization Records Office
0710 James Hall • Telephone (718) 951-4505 • Fax (718) 951-4278

Student Immunization Record

Immunization Record

Part I: Student Information (To be completed by all students)

Name _____
Last First Middle Initial

Street or postal address _____ Apartment no. _____

City _____ State _____ ZIP code _____

Telephone(s) _____
Day Evening/Other

Date of birth _____ EMPLID #. _____
Month Day Year

Initial date of enrollment at Brooklyn College: Year _____ ❍ Fall ❍ Spring ❍ Summer
❍ Undergraduate ❍ Graduate

❍ I was born before January 1, 1957, and have submitted proof of my birth date to the Registrar's Office.

Part II: Student Immunization Record (To be signed and stamped by health care provider)

NOTE: All vaccinations must be administered after student's first birthday to be valid.
Measles: Vaccination must be after 1967. Two doses are required. Second dose must be at least 28 days after first dose and after recipient is 15 months of age.
Mumps and Rubella: Vaccinations must be after 1968.
To prove immunity, verification that these vaccination requirements have been met must be provided.

Proof of immunity is provided by verifying vaccination **OR** serology for each disease, except where not allowed as shown by a shaded area in the table below.

	Measles	Mumps	Rubella	Combined MMR
Vaccination date Dose 1				
Vaccination date Dose 2*				
Serology date and results **(Attach copy of lab report)**				

* If the student has not received a second dose of measles vaccine, please list the scheduled date for dose 2:

_____

This form must be signed and stamped by a physician, nurse, or school official.

I, _____, certify that the above information is correct.
(physician, nurse, or school official)

Signature _____

Title _____

Date _____

Telephone _____

Physician or School Stamp

Part III : Exemption from Immunization

NOTE: If there is an outbreak of measles on campus, any student without proof of immunity (including students with medical and religious exemptions) will be excluded from campus for at least two weeks without tuition refund.

Part III-A Medical Exemption from Immunization

(Part III-A must be filled out, signed, and stamped by a physician or nurse practitioner. Please provide expiration date of exemption or indicate if exemption is permanent.)

I, _____, certify that it is medically contraindicated for the person named in Part I to be vaccinated for the disease(s) indicated below because of the medical reasons stated below.

_____

_____

Expiration date _____ Permanent exemption _____

Signature_____

Title _____

Date _____

Telephone _____

Physician or Nurse Practitioner Stamp

Part III-B Religious Exemption from Immunization

(Part III-B must be completed by the student, or by a parent or guardian if student is under 18.)

Statement of Specific Religious Beliefs

I, _____ request that I / my child, _____
Full Name (Circle One) Full Name

be exempt from vaccination requirements as provided by law because of specific religious beliefs stated below.

_____

_____

_____

Signature (of student if 18 or older or of parent or guardian if student is a minor) _____

Parent or Guardian Information (if student is under 18)

Name _____
Last First Middle Initial

Street or postal address _____ Apartment no. _____

City _____ State _____ ZIP code _____

Telephone(s) _____
Day Evening/Other