ADELPHI UNIVERSITY
The Office of Summer, Intersession, and Partnership Programs
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Summer Pre-College Program
Immunization Record

GENERAL INFORMATION *All information is required and entries must be written in English. Please print.*

Last Name _____ First Name _____ MI _____

Preferred Name _____ DOB _____

**To comply with New York State immunization law, you must have some combination equivalent to two doses of the measles vaccine, one mumps vaccine and one rubella vaccine OR provide serological evidence of immunity (titers).*

REQUIRED IMMUNIZATIONS (To be Completed by a Healthcare Provider ONLY)

MMR (Measles, Mumps, Rubella) *If given as a combined dose instead of individual immunization*

____ Dose 1: Immunized After 1971 and NO MORE THAN 4 Days Prior to First Birthday Date _____/_____/_____

____ Dose 2: Immunized as Above AND at Least 28 Days After First Dose of MMR Date _____/_____/_____

O R

Measles *Two Doses AT LEAST 28 Days Apart, Given After 1967 and No More Than 4 Days Prior to First Birthday*

____ Dose 1: Immunized on or After January 1, 1968 Date _____/_____/_____

____ Dose 2: Immunized as Above AND at Least 28 Days After First Dose of Measles Date _____/_____/_____

Mumps *One dose after January 1, 1968* Date _____/_____/_____

Rubella (German Measles) *One dose after January 1, 1968* Date _____/_____/_____

OR

SEROLOGIC EVIDENCE OF IMMUNITY FOR EACH DISEASE

**Lab Reports Verifying Immunity (IgG) to Measles, Mumps and Rubella REQUIRED (Titers).*

____ Lab Reports Attached

RECOMMENDED IMMUNIZATIONS FOR PRE-COLLEGE STUDENTS

TDap (Booster Recommended for ALL Students) _____/_____/_____ Meningococcal Vaccine _____/_____/_____

OR

Tetanus Toxoid (Within 10 Years) _____/_____/_____

Chicken Pox (Varicella) Immunization 1 _____/_____/_____ 2 _____/_____/_____ OR Date of Disease _____/_____/_____

Flu Vaccination Date _____/_____/_____

Hepatitis B Series 1 _____ 2 _____ 3 _____

Hepatitis A Series *(If Considering or Definitely Travelling Abroad)* 1 _____/_____/_____ 2 _____/_____/_____

Gardasil Series 1 _____/_____/_____ 2 _____ 3 _____

COVID-19 Vaccine and Booster(s) 1 _____/_____/_____ 2 _____/_____/_____ 3 _____/_____/_____

Healthcare Provider's Name _____ Phone _____

Signature _____ License No.* _____ Date _____

STAMP HERE

**This form will NOT be accepted without the healthcare provider's signature and stamp or license number if no stamp is available.*