Fulton-Montgomery Community College
PROOF OF MEASLES, MUMPS & RUBELLA
(must be completed and signed by a health care provider/nurse)

OFFICE USE ONLY
PARTIAL
COMPLETE

Name: _____ **Date of Birth:** _____

FOR ALL STUDENTS BORN ON OR AFTER JANUARY 1, 1957, *New York State Public Health Law 2165 requires students who are registered for 6 credits or more and attending a NYS college must provide documentation, by a health practitioner, of immunity against rubeola (measles), mumps, and rubella (German measles). All vaccines must have been given exactly after 12 months of age to be acceptable. Students who have not complied within 30 days will be* WITHDRAWN *without refund from all classes.*

The following resources may be used to obtain documents containing evidence of immunity:
1. *Health records/immunization records from prior schools.*
2. *Records located at your doctor's office or*
3. *Baby records book or clinic record card, if signed by a health practitioner.*
4. *You can also be immunized by your doctor, health care provider or a local health department.*
   Montgomery County Public Health 518-853-3531
   Fulton County Public Health 518-736-5720

- ***MEASLES:*** Two doses of measles vaccine, the first after exactly 12 months of age and the second on or after fifteen months of age, or physician documented history of disease, or serologic evidence of immunity (titer). *NOTE:* Both immunizations must be given after 1967.
- ***RUBELLA:*** One dose of rubella vaccine on or after 12 months of age, or serologic evidence of immunity (titer).
- ***MUMPS:*** One dose of mumps vaccine on or after 12 months of age or physician documented history of disease (exact date), or serologic evidence of immunity (titer).

MMR: (Measles, Mumps, & Rubella combined vaccine): Two doses required:

DOSE 1: (given on or after first birthday) _____/_____/_____ **Month Day Year**

DOSE 2: (given at least 28 days after dose 1) _____/_____/_____ **Month Day Year**

OR If Measles, Mumps & Rubella are given as individual vaccines:

MEASLES: (complete only one line)

Date of positive titer: _____
or
Date of disease: _____
or
Date of 1st dose: _____

MUMPS: (complete only one line)

Date of positive titer: _____
or
Date of disease: _____
or
Date of Immunization: _____

RUBELLA: (complete only one line)

Date of positive titer: _____ **or** **Date of Immunization:** _____

FORM MUST BE SIGNED BY THE HEALTH CARE PROVIDER/NURSE TO BE OFFICIAL

MEDICAL FACILITY STAMP

_____
Name and Address of Health Facility

_____
Signature of Health Practitioner *Date*