VILLA MARIA COLLEGE IMMUNIZATION RECORDS

WHEN COMPLETED PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS TO SUBMIT:
EMAIL: HEALTHRECORDS@VILLA.EDU FAX: 716-896-0705 *or* MAIL: STUDENT AFFAIRS, 240 PINE RIDGE ROAD BUFFALO, NY 14225

Name _____
LAST NAME FIRST NAME

Date of Birth _____ **Semester of Entry**(circle one) Fall Spring **Year** _____

Address _____
Street City

_____
State Zip

Phone Number (_____) _____ **Email** _____

TO BE COMPLETED BY A HEALTHCARE PROVIDER ***OR*** ATTACH OFFICIAL IMMUNIZATION RECORD

IMMUNIZATION HISTORY (All dates must include month, day and year.)	
REQUIRED: MMR (measles, mumps, rubella) – if given as combined dose instead of individual vaccine	DATE (MM/DD/YEAR)
MMR Dose 1: No more than 4 days prior to first birthday	
MMR Dose 2: At least 28 days after first vaccine	
or	DATE (MM/DD/YEAR)
Measles (Rubeola) Dose 1 after first birthday	
Measles (Rubeola) Dose 2 at least 28 days after first dose	
Rubella Immunized on or after first birthday	
Mumps Immunized on or after first birthday	
or	DATE (MM/DD/YEAR)
Titer (blood test) showing positive immunity (dated lab results must be attached)	
Measles IgG	
Mumps IgG	
Rubella IgG	
RECOMMENDED: MENINGOCCAL VACCINE (MUST BE WITHIN PAST FIVE YEARS)	
DOSE 1	
HEALTHCARE PROVIDER INFORMATION (signature and stamp required)	
PROVIDER SIGNATURE _____ PROVIDER NAME PRINTED _____ ADDRESS _____ TELEPHONE NUMBER _____ DATE _____	HEALTHCARE PROVIDER STAMP

THIS MENINGITIS RESPONSE IS REQUIRED FOR ALL STUDENTS NOT VACCINATED IN THE PAST 5 YEARS
Meningitis vaccination is not mandated; however, completion of the survey is required. We strongly urge you to read full information regarding meningitis at: https://www.villa.edu/campus-life/student-services/student-health-services/.

- ☐ I have read, or have explained to me, the information regarding meningococcal disease. I (my child) will obtain the immunization against meningococcal disease **within 30 days** from my private health care provider.
- ☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Date : / /

Signature (Parent/Guardian if under 18 years old)

ALL students must submit this form ***OR*** official immunization record **prior** to class attendance. Failure to do so will result in removal of schedule in compliance with New York State Public Health Law. **PTA and OTA** students are **required** to have additional immunizations to participate in clinical internship.