COLLEGE OF
MOUNT SAINT VINCENT
IMMUNIZATION RECORDS

Return to: 6301 Riverdale Avenue, Riverdale, NY 10471 or immunizationrecords@mountsaintvincent.edu

Student's Name: _____ Date of Birth: _____

Cell Phone: # _____ CMSV ID #: _____

Mandatory Immunizations: To be completed by healthcare provider

New York State Health Law: Exact dates (MM/DD/YYYY) are required for all immunizations. Proof of immunity by titer is also acceptable. Copy of lab results must be attached.

MMR: (2 doses required, 1st dose must be on or after 1st birthday)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ or ☐ immune by ____/____/____

OR

Measles: (2 doses required, 1st dose must be on or after 1st birthday)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ or ☐ immune by ____/____/____

Mumps: (2 doses required, 1st dose must be on or after 1st birthday)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ or ☐ immune by ____/____/____

Rubella: (2 doses required, 1st dose must be on or after 1st birthday)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ or ☐ immune by ____/____/____

Meningitis Vaccine

☐ Not vaccinated (Must sign waiver below) ☐ Vaccinated: ____/____/____

Resident Students: You must document that you received either Menactra® or Menveo® at or after age 16 to live in the residence halls.

If the Meningitis Vaccine has *NOT* been received, review the Meningitis Information on the college website: www.mountsaintvincent.edu/healthforms before signing this waiver**.** I have read or have had the information regarding Meningococcal Meningitis disease explained to me. I understand the risks of **not** receiving the vaccine. I have decided that I **or** my child if he/she is under the age of 18 years old will not receive the immunization against Meningococcal Meningitis disease.

Signature: _____ Date: _____

COVID-19 Vaccine

Name of vaccine received: _____ (Moderna, Pfizer, Janssen/Johnson & Johnson)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ ☐ Booster ____/____/____ (recommended)

Healthcare Provider Signature: _____

Healthcare Provider Name: _____

State/License #: _____

Office Address (Stamp):

(REV. 3/2022)