UNIVERSITY OF
MOUNT SAINT VINCENT

2024-2025 Immunization Form

Return to: Student Affairs office in Founders Hall 105 or mail to, Student Affairs, 6301 Riverdale Avenue, Riverdale, NY 10471 or immunizationrecords@mountsaintvincent.edu or you may bring to your Orientation Preview Day session in June or July.

Student's Name: ___________________________ Date of Birth: ____________________________

Cell Phone: # ___________________________ UMSV 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 university 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:** _________

Healthcare Provider Signature: ________________________ Office Address (Stamp Here):

Healthcare Provider Name: ___________________________

State/License #: _____________________________________