



Exploring Differences, Deepening Faith

GRADUATE PROGRAM - IMMUNIZATION VERIFICATION FORM

Connecticut State Law requires that all students born after December 31, 1956 and enrolled in post-secondary schools be protected against measles, rubella, mumps and varicella and show proof of that protection. Additionally, students living on-campus are required to be immunized against meningitis. This form must be completed before registering for classes as a matriculated student.

This section should be completed by the student. Please print or type.

Student Name (Last, First, MI)	Date of Birth	Country of Birth
Physician's Name / Address		Physician Phone # () -

This section must be completed by either a physician or someone operating under the direction of a physician, i.e. nurse, physician's assistant, nurse practitioner.

RECORD OF IMMUNIZATION or DOCUMENTED IMMUNITY

	1st Dose	2nd Dose	OR
Measles 2 doses or documented immunity. Dose #1 on or after first birthday. Dose #2 at least 30 days after the 1st dose and after 1/1/80	____/____/____ Month/Day/Year Must be on or after the first birthday.	____/____/____ Month/Day/Year Must be at least 30 days after the first dose and after 1/1/80.	<input type="checkbox"/> Positive titer report attached or history of a confirmed case of the disease.
Rubella 2 doses or documented immunity.	____/____/____ Month/Day/Year	____/____/____ Month/Day/Year	<input type="checkbox"/> Positive titer report attached or history of a confirmed case of the disease.
Mumps 2 doses or documented immunity.	____/____/____ Month/Day/Year	____/____/____ Month/Day/Year	<input type="checkbox"/> Positive titer report attached or history of a confirmed case of the disease.
Varicella 2 doses or documented immunity required of students born after 1/1/1980 or born outside the United States.	____/____/____ Month/Day/Year	____/____/____ Month/Day/Year	<input type="checkbox"/> Positive titer report attached or history of a confirmed case of the disease.
Meningitis 1 dose required of students living on campus.	____/____/____ Month/Day/Year		

I hereby certify that this student has received the required immunization(s) or has laboratory evidence of immunity as indicated.

Signature of Physician or Person Authorized by Physician to sign

Date