

**Siena College Student Immunization Record: MUST BE SUBMITTED PRIOR TO START OF CLASSES**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**This form must be completed by a health care professional, in its entirety, in English, prior to Registration**

*Please Upload Completed Form to [www.siena.edu/healthportal](http://www.siena.edu/healthportal)*

**REQUIRED IMMUNIZATIONS:**

<b>MMR</b> (combined measles, mumps, rubella): is <b>required</b> - NYS Public Health Law <ul style="list-style-type: none"> <li><b>TWO</b> Doses required after 1<sup>st</sup> birthday and at least 28 days apart and after 1/1/68</li> </ul>	<b>Dose #1:</b> _____ / _____ / _____ <b>Dose #2:</b> _____ / _____ / _____
<b>MEASLES</b> (if MMR not given): <b>ONE</b> of the following is <b>required</b> – NYS Public Health Law <ul style="list-style-type: none"> <li>Born before 1957 and therefore considered immune <input type="checkbox"/> YES</li> <li><b>TWO</b> doses required after 1<sup>st</sup> birthday and at least 28 days apart and after 1/1/68</li> <li><b>OR</b> Titer (blood test , serology) confirming immunity – <b>MUST ATTACH LAB RESULTS</b></li> </ul>	<b>Dose #1:</b> _____ / _____ / _____ <b>Dose #2:</b> _____ / _____ / _____ <b>Titer Date:</b> _____ / _____ / _____ <b>Result:</b> _____
<b>MUMPS</b> (if MMR not given): <b>ONE</b> of the following is <b>required</b> - NYS Public Health Law <ul style="list-style-type: none"> <li><b>ONE</b> dose required after first birthday and after 1/1/68</li> <li><b>OR</b> Titer (blood test, serology) confirming immunity – <b>MUST ATTACH LAB RESULTS</b></li> </ul>	<b>Dose #1:</b> _____ / _____ / _____ <b>Titer Date:</b> _____ / _____ / _____ <b>Result:</b> _____
<b>RUBELLA</b> (if MMR not given): <b>ONE</b> of the following is <b>required</b> - NYS Public Health Law <ul style="list-style-type: none"> <li><b>ONE</b> dose required after first birthday and after 1/1/68</li> <li><b>OR</b> Titer (blood test, serology) confirming immunity –<b>MUST ATTACH LAB RESULTS</b></li> </ul>	<b>Dose #1:</b> _____ / _____ / _____ <b>Titer Date:</b> _____ / _____ / _____ <b>Result:</b> _____
<b>MENINGOCOCCAL (Menactra or Menveo)– Siena requirement</b> <ul style="list-style-type: none"> <li><b>ONE</b> dose at age 16 or older and within 5 years</li> </ul>	<b>Date:</b> _____ / _____ / _____
<b>TETANUS/ DIPHTHERIA/ PERTUSSIS (TdaP) – Siena requirement</b> <ul style="list-style-type: none"> <li>Required Booster within 10 years</li> </ul>	<b>Date:</b> _____ / _____ / _____
<b>COVID-19 VACCINE</b> [ ] Moderna 2 dose series    [ ] Pfizer 2 dose series [ ] Johnson & Johnson 1 dose	<b>Dose #1:</b> _____ / _____ / _____ <b>Dose #2:</b> _____ / _____ / _____ <b>Dose #1:</b> _____ / _____ / _____

**Strongly Recommended Additional Immunizations: (Not required for registration)**

<b>HEPATITIS A</b>	<b>Dose #1:</b> _____ / _____ / _____ <b>Dose #2:</b> _____ / _____ / _____
<b>HEPATITIS B</b>	<b>Dose #1:</b> _____ / _____ / _____ <b>Dose #2:</b> _____ / _____ / _____ <b>Dose #3:</b> _____ / _____ / _____
<b>POLIO – completed primary set of Polio Vaccine</b>	<b>Date:</b> _____ / _____ / _____

**HEALTH CARE PROVIDER SIGNATURE REQUIRED:**

Health Care Provider's Signature \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE# \_\_\_\_\_ FAX# \_\_\_\_\_