Brooklyn College • Division of Student Affairs • Health Programs and Immunization Records Office 0710 James Hall • Telephone (718) 951-4505 • Fax (718) 951-4278

Part I: Student Information (To be completed by all students)

Name					
Last		First		Middle Initial Apartment no	
Street or postal address					
City	State		ZIP	code	
Telephone(s)					
Telephone(s)		Evening/Ot	her		
Date of birth		EMPLID #			
Month Day	Year				
Initial date of enrollment at Brooklyn (College: Year			Spring O Summ raduate O Gradu	
O I was born before January I, 1957,	and have subm	nitted proof of m	ny birth date to	the Registrar's Office	ce.
Measles: Vaccination must be a 28 days after first dose and after Mumps and Rubella: Vaccination To prove immunity, verification Proof of immunity is provided by verification	recipient is 15 nons must be after that these vaccin ying vaccination	nonths of age. 1968. ation requirement OR serology fo	s have been met	must be provided.	
allowed as shown by a shaded area in	The table belov	V. T		1	
	Measles	Mumps	Rubella	Combined MMF	₹
Vaccination date Dose I					
Vaccination date Dose 2*					
Serology date and results (Attach copy of lab report)					
* If the student has not received a sec	ond dose of m	easles vaccine, p —	lease list the scl	neduled date for do	ose 2:
This form must be signed and	l stamped b	y a physician	, nurse, or s	chool official.	
		, certify that t	he above inforr	mation is correct.	
(physician, nurse, or school official)					
Signature			6.116.		
Title			an or School St	amp	
Date		_			
T. L L					

Student Immunization Record

Part III: Exemption from Immunization

NOTE: If there is an outbreak of measles on campus, any student without proof of immunity (including students with medical and religious exemptions) will be excluded from campus for at least two weeks without tuition refund.

Part III-A Medical Exemption from Immunization

•	oust be filled out, sign f exemption is perma		ian or nurse practitioner. Plea	se provide expiration date of exemption			
			fy that it is medically contrainc the medical reasons stated bel	icated for the person named in Part I to ow.			
Expiration da	ate		Permanent exemption				
Signature			Physician or Nurse Practitioner Stamp				
Title							
Date							
Telephone _							
Statemen	nt of Specific Re	ligious Beliefs request t	or guardian if student is under hat I / my child, cle One) Full Name				
be exempt f	from vaccination req	uirements as provided by lav	v because of specific religious l	peliefs stated below.			
Signature (of	fstudent if 18 or older	or of parent or guardian if stud	ent is a minor)				
Parent or G	Guardian Information	n (if student is under 18)					
Name	Last	First	Middle Initial				
Street or po	ostal address			Apartment no			
City			State ZIP code				
Telephone(s	S)			Other			