

MEASLES/RUBELLA IMMUNIZATION CERTIFICATION INFORMATION SHEET

This is to inform you that the Public Act 89 - 90 requires all Connecticut college students born after **December 31, 1956** provide the Health Office with documentation of adequate immunization against measles and rubella. As a result, Albertus Magnus College must take the necessary measures as mandated by the state statute.

Adequate immunization according to State Statute:

MEASLES: All new and readmitted students born after **December 31, 1956** must provide proof of two (2) doses of measles vaccine - one dose administered after **January 1, 1969** and after the students first birthday. The second dose of measles vaccine required, to be given at least 30 days after the first dose.

RUBELLA: (German Measles): one (1) dose administered after the students first birthday is considered adequate immunization.

Students registering at Albertus Magnus College will be required to bring proof of immunization for measles and rubella prior to registration. **ANY STUDENT NOT SHOWING THE NECESSARY PROOF OF IMMUNIZATION WILL NOT BE ABLE TO REGISTER.** One of the following documents is necessary: a medical record, a physician's statement, your elementary or secondary school health record, or proof of immune titer. Appropriate documentation is required for a medical or religious exemption.

If you need further assistance please contact the Dean of Student Services at (203) 773-8541.

Please mail all health forms to:
Albertus Magnus College
Dean of Student Services
700 Prospect Street
New Haven, CT 06511

STATE LAW REQUIRES THAT THIS FORM BE COMPLETED AND ON FILE WITH THE COLLEGE PRIOR TO ATTENDING CLASSES.

Albertus Magnus College
 Dean of Student Services
 700 Prospect Street
 New Haven, CT 06511

Pre Admission Immunization Requirements
 (Please Print or Type)

Name of Student (Last, First, Middle) _____

Address (Street) _____

City/Town _____ **State** _____ **Zip** _____

Home Phone # (____) _____ **Emergency Phone #** (____) _____

Birth Date ____ \ ____ \ ____ **Sex** M \ F

Parent or Guardian (Last, First, Middle) _____

Physician's Name _____

IMMUNIZATION HISTORY
 (Must be Completed by a Physician)

Record of Immunization (Primary Immunization Series)

Vaccine Type	1st Dose MO/DAY/YR.	2nd Dose MO/DAY/YR.	3rd Dose MO/DAY/YR.	4th Dose MO/DAY/YR.
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TD (Adult)				
Oral Polio				
Measles				
Rubella				
Mumps				

1 Physician Statement of Verification

2 Laboratory Verification for Disease History

I certify that this student has received the immunization (s) indicated

Physician's Signature _____ **Date** ____ \ ____ \ ____