NORTH COUNTRY COMMUNITY COLLEGE

MMR Immunization Validation Form

Name: _____ Other Names Used: _____

Address: _____ Date of Birth _____

NY State Public Health Law 2165 requires all post-secondary students born on or after January 1, 1957, and enrolled in six or more credit hours, to provide proof of immunity to measles, mumps, and rubella. Appropriate documentation must include ONE of the following:

- Documentation of TWO (2) MMR vaccinations. To be considered valid, the first vaccination cannot be administered any more than four days prior to the student's first birthday, and the second dose must be given at least 28 days after the first dose.
- Documentation of TWO (2) doses of the measles vaccination, ONE (1) dose of the mumps vaccination, and ONE (1) dose of the rubella vaccination. To be considered valid, neither vaccination can be administered any more than four days prior to the student's first birthday, and the SECOND dose of the measles vaccination must be given at least 28 days after the first dose.
- POSITIVE blood titer results for measles, mumps, and rubella. **Copies of a lab report(s) validating these results must be submitted.**

To assist with documenting one of the above options, you may choose to have your health care provider complete this form. **Please note that, if you are able to obtain a copy of your immunization record from another source (high school, another college, military, etc.), it is NOT necessary to complete this form.**

To be completed by a health care provider, NOT the student or student's parent/guardian

OPTION 1	OPTION 2
Date of MMR #1 _____ Date of MMR #2 _____ OR Date of Measles #1 _____ Date of Measles #2 _____ Date of Mumps #1 _____ Date of Rubella #1 _____	Date of **POSITIVE** Blood Titers *A copy of lab report must be attached to verify results.* + Measles Blood Titer Date _____ + Mumps Blood Titer Date _____ + Rubella Blood Titer Date _____

The above vaccination(s) have been validated by:

Health Care Provider name (printed) _____ Telephone Number

Address _____ _____
Street City State Zip

HCP's Signature _____

The medical office's stamp validating this information can be used in lieu of the provider's signature.

Date _____

Please fax this completed form to 518-897-3474 OR Email to healthrecords@nccc.edu