St. Lawrence University Student Health Service

*This form is **required** for all new, incoming students and is to be completed, signed, and dated below by your health care provider.*

Due: July 20th
Return form to:
Student Health Service
76 Park Street
Canton, NY 13617
Or fax: 315-229-5514

Questions about requirements? Email: healthcenter@stlawu.edu

Last Name	**First Name**	**Date of Birth:** _____/____/_____ M D Y
Home City and State/Country	**Phone** ☐ Cell ☐ Home	**Gender**: ☐ Male ☐ Female ☐ Transgender

REQUIRED VACCINATIONS

Measles, Mumps, Rubella MMR if combined*	**2 doses or a positive titer. Dose #1 on or after 1st birthday, Dose #2 ≥ 28 days after dose #1**	**MMR Dose #1** _____/_____/_____ M D Y	**MMR Dose #2** _____/_____/_____ M D Y	☐ **Titer attached**
***OR if single vaccines**	**2 single doses of measles vaccine, 1 single dose of mumps vaccine, 1 single dose rubella vaccine or positive titers. Measles Dose #1 on or after 1st birthday, Dose #2 ≥ 28 days after dose #1**	**Measles Dose #1** ___/___/___ M D Y **Mumps Dose #1** ___/___/___ **Rubella Dose #1** ___/___/___ M D Y	**Measles Dose #2** ___/___/___ M D Y	☐ ***Titer attached*** ☐ ***Titer attached*** ☐ ***Titer attached***
Meningococcal Meningitis	**Type:** ☐ **Menactra** ☐ **Menveo** ☐ **Other** _____	**Dose #1** ___/___/___ M D Y	**Dose #2** (if indicated) ___/___/___ M D Y	***OR Signed waiver attached*** ☐

Diphtheria, Tetanus, Pertussis	**Series of 5 doses**	**Dose #1** ___/___/___ M D Y	**Dose #2** ___/___/___ M D Y	**Dose #3** ___/___/___ M D Y	**Dose #4** ___/___/___ M D Y	**Dose #5** ___/___/___ M D Y
Adult Tetanus/ Diphtheria, Pertussis Booster	**1 dose within 10 years** **Type:** ☐ **TD** ☐ **Tdap**	___/___/___ M D Y				
Polio Vaccine	**Dates of 3 primary series and Booster** **Type:** ☐ **OPV** ☐ **IPV**	**Dose #1** ___/___/___ M D Y	**Dose #2** ___/___/___ M D Y	**Dose #3** ___/___/___ M D Y	**Booster** ___/___/___ M D Y	

RECOMMENDED VACCINATIONS

Hepatitis A (indicate M/D/Y)	___/___/___ M D Y	___/___/___ M D Y		
Hepatitis B (indicate M/D/Y)	___/___/___ M D Y	___/___/___ M D Y	___/___/___ M D Y	
Varicella (ChickenPox) (indicate M/D/Y)	**Clinician Documented disease** ___/___/___ M D Y	**Dose #1** ___/___/___ M D Y	**Dose #2** ___/___/___ M D Y	☐ **Titer attached**
Quadrivalent HPV Vaccination Series (indicate M/D/Y)	**Dose #1** ___/___/___ M D Y	**Dose #2** ___/___/___ M D Y	**Dose #3** ___/___/___ M D Y	

Provider ***(please print)***	**Address**	**Phone/Fax**
☐ **Student is compliant with the vaccination requirements recorded above, or attached separately.**	**Provider Signature:** **Date:**	