



Utica University Immunization Verification Form Health and Wellness Center

How to submit this form:

Upload to Student Health Portal www.utica.studenthealthportal.com

Email: HWC@utica.edu

Fax: 315-792-3700

Questions? Contact Health and Wellness Center at 315-792-3094 or HWC@utica.edu

Due Date: July 1 for Fall semester

How to complete this form:

To meet New York State immunization requirements, you must:

Option 1: Have this form completed and signed or stamped by a healthcare provider

OR

Option 2: Submit this form along with an official copy of your immunization records from a source listed below
(Provider signature is not required if records are included)

Acceptable Documentation:

Official immunization records must include your name and date of birth and must be issued by one of the following:

- Healthcare provider or medical office records
- School health records
- Official Immunization Registry (NYSIIS)
- Military immunization records

All records must clearly show vaccine dates (month/day/year)

Student's Required Personal Information		
Utica University ID#:	Birth Date (MM/DD/YY): ____/____/____	
Last Name:	First Name:	MI:

Measles, Mumps, Rubella (MMR) REQUIREMENT (Required for all students)
Check ONE option below

<input type="checkbox"/> Option A: I have received 2 MMR Vaccines	Date of Dose 1 ____/____/____ Date of Dose 2 ____/____/____
OR	
<input type="checkbox"/> Option B: I am submitting Positive Titers (Lab results must be attached) <input type="checkbox"/> Measles Immune <input type="checkbox"/> Mumps Immune <input type="checkbox"/> Rubella Immune	Date of Titer ____/____/____

Student Name: _____

Date of Birth: _____

Meningitis REQUIREMENT (Required for all students)

Check ONE option below

Option A: I have received the meningitis vaccine

Date of most recent dose: _____ / _____ / _____

(Must be given within the last 5 years)

OR

Option B: I decline the meningitis vaccine

*I understand the risks of meningococcal disease and the benefits of immunization at the recommended ages. I have decided that I (my child) will **not** obtain immunization against meningococcal disease at this time.*

Student Signature: _____

Date: _____

(Parent Signature if student is under age 18) _____

Date: _____

Provider's Signature (ONLY if form is completed by healthcare provider)

Physician Name (Signature):

Date:

Address:

City/State, Zip Code:

Telephone:

Fax

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