BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

Decker Student Health Services Center
Phone: 607-777-2221
Fax: 607-777-2881
https://binghamton.medicatconnect.com/

CERTIFICATE OF IMMUNIZATION

Last Name:		First Name:	
BNumber:	Local Phone:	Permanent Phone:	Date of Birth (mm/dd/yy):

REQUIRED IMMUNIZATIONS

Measles, Mumps, Rubella For all born after 12/31/1956, 2 doses (dose 1 must be administered at least 361 days after birth and 2nd dose given a minimum of 4 weeks later) or a blood test showing immunity. **Please attach any titer documentation.**	**1st MMR Dose** ____/____/____ Month Day Year	**2nd MMR Dose** ____/____/____ Month Day Year	**3rd MMR Dose** ____/____/____ Month Day Year

Measles Dose 1 ____/____/____ Month Day Year	**Measles Dose 2** ____/____/____ Month Day Year	**Mumps Dose 1** ____/____/____ Month Day Year	**Rubella Dose 1** ____/____/____ Month Day Year

Meningococcal (serogroups A, C, W, Y) If you have not entered an administration date that is within 5 years for the Meningococcal Vaccine (serogroup A, C, W, Y) you must acknowledge that you have reviewed the meningitis disease vaccine information https://www.binghamton.edu/health/docs/information_about_the_meningococcal_meningitis_vaccine_health_requirement.pdf and, with your below signature, acknowledge that you are aware of the meningococcal disease risks and that you decline the meningococcal meningitis immunization.	____/____/____ Month Day Year ____/____/____ Month Day Year	☐ Menactra ☐ Menveo ☐ MCV4 (A, C, Y, W-135) ☐ Other ☐ Menactra ☐ Menveo ☐ MCV4 (A, C, Y, W-135) ☐ Other

Signature of Student or Parent/Guardian if Student is Under 18 Years of Age

Tuberculosis **BINGHAMTON UNIVERSITY DOES NOT ACCEPT TB SKIN TEST (PPD) RESULTS PLACED BY PROVIDERS OUTSIDE THE UNITED STATES OR CANADA.** Please go to https://www.binghamton.edu/health/new-student-information.html for information regarding this requirement.

NON-REQUIRED IMMUNIZATIONS ☐

Tetanus-Diphtheria and Pertussis Record date and type of **most recent** tetanus-diphtheria vaccine.	____/____/____ Month Day Year	☐ Tdap ☐ Td

Gardasil HPV Vaccine	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	**Dose 3** ____/____/____ Month Day Year
Hepatitis B Vaccine	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	**Dose 3** ____/____/____ Month Day Year
Varicella Vaccine (Chicken Pox)	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	**Illness** ____/____/____ Month Day Year
Hepatitis A Vaccine	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	☐
Meningococcal Vaccine (serogroup B)	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	**Dose 3** ____/____/____ Month Day Year ☐ Bexsero ☐ Trumenba

Health Care Provider Information

Provider Name (Please Print):		Title:
Signature:	Phone:	Date: ____/____/____ Month Day Year
Address:		