



St. Vincent's COLLEGE

2800 Main Street
Bridgeport, CT 06606
(203) 576-5651, Fax (203) 576-5318
www.stvincentscollege.edu

PROOF OF IMMUNIZATION

Name of Student: _____ Date of Birth: _____

Social Security Number: _____

Address: _____ Phone Number: _____

St. Vincent's Medical Center requires that all students in St. Vincent's College provide proof of immunization/immunity from your health care provider for the following:

(Measles documentation required only if born after 12/31/56)

Measles Vaccine	1 st dose _____ (After age 1 and 1/1/69)	OR	Measles Titer _____ (Date) (Result)
	2 nd dose _____ (After 1/1/80)		

Rubella Vaccine	_____	OR	Rubella Titer _____
	(After age 1)		(Date) (Result)

I acknowledge completing the required immunization/immunity testing for the above named student on:

Date: _____

Health Care Provider's Name: _____

Address: _____

Phone: _____

Signature: _____

Official
Stamp
or
Seal