

Student Health Services
Student Immunization Requirements
Health Clearance Form

Name _____ DOB _____ SS# _____

St. Vincent's College and St. Vincent's Medical Center require that all students provide, from their physician, proof of immunity of vaccination for the following diseases. When completed and once you are accepted as a student, CALL (203) 268-2501 FOR AN APPOINTMENT TO BE HEALTH CLEARED THROUGH OUR EMPLOYEE HEALTH DEPT. Bring this completed form with you.

1. German Measles

Rubella Vaccine Date _____
OR
Rubella Titer Date _____ Result _____

2. Measles

Measles Vaccine
1st Dose Date (after 1/1/69) _____
2nd Dose Date (after 1/1/80) _____
OR
Measles Titer
Date _____ Result _____

3. Mumps

Mumps Vaccine Date _____
OR
Mumps Titer Date _____ Result _____

4. Tetanus/Diphthera

TD Vaccine-Required every 10 years
Date _____

5. Hepatitis B

1st dose Date _____
2nd dose Date _____
3rd dose Date _____
AND
Antibody Titer Date _____ Result _____

6. Meningitis

Meningococcal Vaccine-Optional
Date _____

7. Chickenpox

Varicella Titer Date _____ Result _____
OR
Varicella Vaccine Date _____
Varicella Vaccine Date _____

8. Tuberculosis

Two-Step Tuberculin Skin Test
(Mantoux PPD only)
#1 Date (within 12 months) _____
Result N P _____ mm
#2 Date (within 6 months) _____
Result N P _____ mm
If PPD + obtain CXR
Result _____ Date _____
Prophylactic Therapy
Medication _____
Length of Time _____

(HISTORY OF DISEASE WILL NOT BE ACCEPTED)

I acknowledge completing the above required immunization/immunity testing on _____.

Health Care Provider's Signature _____ **OFFICIAL SEAL OR STAMP**

Health Care Provider Name _____

Address _____

Phone _____