IT'S THE LAW!
NO SHOTS/NO REGISTRATION

New York State Public Health Law 2165 now requires college students to show proof of immunity to measles, mumps, and rubella. This documentation must be on file at the Student Health Center.

Persons born <u>prior to 1/1/57</u> are exempt from this requirement, please <u>return form with proof of age</u>.

If you do not fulfill this requirement, **<u>you will not be able to register for classes.</u>**

You will not be allowed to register unless proper proof of immunizations, on a health record, is on file at the health center. A copy of your school immunization record, which MUST include ALL requirements below, may be submitted for review. Please return the completed forms to:

Weigel Health Center, Buffalo State College, 1300 Elmwood Avenue, Buffalo, NY 14222

Name_____
Last Maiden First M.I.

Address_____
Street City State Zip

Date of Birth___/___/___Social Security #_____/_____/_____ Phone(_____)_____

<u>REQUIRED IMMUNIZATIONS</u>
<u>ALL DATES MUST INCLUDE MONTH, DAY, AND YEAR</u>

REQUIRED: Measles (Rubeola) Immunity

Must have one of the following:

1. **Two** Dates of Measles Immunizations:(1)_____(2)_____
   Both must have been given after 1/1/68 **<u>AND</u>** on or after first birthday.

OR 2. Date of positive Measles Titer_____Results_____
   Copy of titer **REQUIRED**.

OR 3. Date and Signature of Physician that diagnosed Measles_____

REQUIRED: Rubella (German Measles) Immunity

Must have one of the following:

1. Date of ONE Rubella Immunization_____
   <u>Must</u> have been given after 1/1/69 **<u>AND</u>** on or after first birthday.

OR 2. Date and results of Rubella Titer_____
   Copy of titer **REQUIRED.**
   History of this illness in NOT acceptable!!

REQUIRED: Mumps Immunity

Must have one of the following:

1. Date of one Mumps Immunization_____
   <u>Must</u> have been given after 1/1/69 **<u>AND</u>** or after first birthday.

OR 2. Date and results of Mumps Titer_____
   Copy of titer **Required**.

OR 3. Date and Signature of Physician that diagnosed Mumps_____

_____ _____
Signature of Health Care Provider Required Date