

**UNIVERSITY OF ROCHESTER
IMMUNIZATION COMPLIANCE REPORT**

PART-TIME STUDENTS

RETURN FORM IN THE ENVELOPE PROVIDED TO:

University Health Service
University of Rochester
Box 270617, Rochester, NY 14627-0617
PHONE: 585-275-0697 Toll free: 888-363-2519
FAX: 585-756-0263
Website www.rochester.edu/uhs

INSTRUCTIONS – Print all information except signature. Complete in ink.

**A \$26.00 PROCESSING FEE MUST ACCOMPANY SUBMISSION OF THIS FORM.
PLEASE MAKE CHECK PAYABLE TO “UNIVERSITY HEALTH SERVICE”**

PART ONE: STUDENT IDENTIFICATION – TO BE COMPLETED BY STUDENT

NAME LAST		FIRST	M	SSN	DATE
DATE OF BIRTH (mo/day/yr)	AGE	COUNTRY OF RESIDENCE WITHIN PAST 5 YEARS <input type="checkbox"/> US <input type="checkbox"/> Other (specify):		(AREA CODE) PHONE #	
HOME ADDRESS			CITY	STATE	ZIP

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: (H) _____ (W) _____

SCHOOL OR COLLEGE

- 01 The College
- 02 Simon School of Business Administration
- 03 Warner Graduate School of Education & Human Development
- 06 Eastman School of Music
- 07 School of Medicine & Dentistry - Graduate

STATUS

- Part-time Matriculated Undergraduate Student
- Part-time Non-Matriculated Undergraduate Student
- Part-time Matriculated Graduate Student
- Part-time Non-Matriculated Graduate Student

ENTERING SEMESTER and YEAR

- Fall 2009 2012
- Spring 2010 2013
- Summer 2011 2014
- Simon School entering quarter (year above) Fall Winter Spring Summer

PREVIOUS RELATIONSHIP WITH UNIVERSITY

- Previous full time student
- Patient at University Health Service
- Patient at Strong Memorial Hospital
- Previous/current employee or volunteer

PART TWO: IMMUNIZATIONS – TO BE COMPLETED BY HEALTHCARE PRACTITIONER

**For all titers, copy of Laboratory report must accompany this form.*

**SEE “IMMUNIZATION REQUIREMENTS FOR PART-TIME STUDENTS”
ON THE UHS WEB SITE FOR SPECIFIC REQUIREMENTS**

MMR		MEASLES		MUMPS	RUBELLA
#1	#2	#1	#2		
mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr

HEALTHCARE PRACTITIONER Identification

Physician Name (print or stamp)	Signature	Date
Address		Phone

PART THREE: STUDENT CERTIFICATION

I certify that the information submitted on this form is accurate to the best of my knowledge. I certify that I have received information about the risks, benefits, availability and alternatives to Meningococcus Vaccination. I understand the information and have either had Meningococcus Vaccination in the last ten years or choose not to do so. I will contact University Health Service if I have any questions about these issues.

MENINGOCOCCUS

mo/day/yr

Student's Signature

Date

STUDENTS NOT IN COMPLIANCE WITH REQUIREMENTS BY THE START OF FIRST TERM WILL BE SUBJECT TO A LATE FEE AND WILL HAVE SUBSEQUENT SEMESTER REGISTRATIONS BLOCKED.