GOODWIN COLLEGE

IMM

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Proof of Immunization

Connecticut laws require that all full-time and matriculated students attending Connecticut colleges and born on or after January 1, 1957, must submit evidence of immunization against Mumps, Measles, and Rubella as well as submit evidence of immunization against Varicella for those born on or after January 1, 1980. Any student not born in the United States (Puerto Rico is not included) must provide proof of Varicella immunization. Students who will reside in college housing are also required to submit evidence of immunization against Meningitis.

If you cannot obtain any records, a doctor can run a test (titer) for Measles, Mumps, Rubella, and/or Varicella, and/or Menigitis to determine if you need a vaccination. If the test shows that you need a vaccination for Measles, Mumps, Rubella, and/or Varicella, and/or Meningitis, the doctor will give you one and record it on this form. If you received the first vaccination for Measles, Mumps, Rubella, and/or Varicella, you must return to the doctor after one month to receive the second dose. The doctor must sign a note stating that you received this second dose.

Last name: ______ First name: ______ Middle: ______

Date of birth: MM/DD/YY Class start date: ______ Gender Identity: ______

Address: ______

City: ______ State/Province: ______ Zip/Postcode: ______

Home phone: ______ Cell phone: ______ Best time to call: ______

Inoculation Series

MMR - Date of first dose: ______ Date of second dose: ______

Varicella - Date of first dose: ______ Date of second dose: ______

Meningitis - Date of inoculation (must be within 5 years of your first day of classes): ______

OR

Laboratory Verification of Immunity

Required for anyone not providing proof of inoculation series.

Measles titer date: ______ Results: ______

Mumps titer date: ______ Results: ______

Rubella titer date: ______ Results: ______

Varicella titer date: ______ Results: ______

Meningitis titer date: ______ Results: ______

OR

Written Verification of Disease History from a Physician

Please list dates of occurrence below.

Measles: ______ Mumps: ______ Rubella: ______ Varicella: ______ Meningitis: ______

Physician’s name (please print or type): ______

Physician’s Signature: ______ Date: ______