SUNY GCC
Genesee Community College

Student Immunization Form

HEALTH OFFICE | ONE COLLEGE ROAD, BATAVIA, NY 14020
PHONE: **(585) 345-6835** | FAX: **(585) 345-6816**

DUE PRIOR TO START OF CLASSES

Failure to comply with NYS Public Health Law Section 2165 and Section 2167 will result in a hold on your account and you being removed from class.

FOR SCANNING PURPOSES, THIS FORM MUST BE COMPLETED IN BLACK INK.
PLEASE DO NOT USE HIGHLIGHTERS.

NAME (please print): _____
Last First MI

GCC Student 800 #: _____

BIRTHDATE: _____ / _____ / _____
Month Day Year

REQUIRED VACCINES:

Must be completed and signed by a healthcare provider **OR** attach immunization records from previous school, healthcare provider or government agency.

A. MMR (Measles, Mumps, Rubella) *REQUIRED*

Vaccination	Vaccine Date (Month/Day/Year)	*Or* Attach Lab Results/Date
2 MMR's (Measles, mumps & rubella vaccine) 1st dose after 1st birthday; 2nd dose at least 28 days later OR individual vaccines below	#1	
	#2	
OR		
2 MEASLES 1st dose after 1/1/68 and after 1st birthday; 2nd dose at least 28 days later	#1	
	#2	
1 MUMPS After 1/1/69 and first birthday		
1 RUBELLA After 1/1/69 and after 1st birthday		

FORMS ARE DUE BEFORE THE START OF CLASSES
ORIGINAL FORMS WILL NOT BE RETURNED

B. Meningitis Information Form *REQUIRED*

New York State Public Health Law requires all students to verify that they have received information about meningococcal disease and made an informed decision about immunization. Review this information at www.health.ny.gov/publications/2168/, in the health service office or at http://www.genesee.edu/home/campus-life /student-health-center/

Choose one of the following:

Meningitis ACWY (within 5 years)	**Vaccination Date:**
OR	
Meningitis WAIVER	(No healthcare provider signature needed for waiver) I have read and understand the meningitis information and the risks associated with meningitis and decline immunization. SIGN: _____ Date: _____ Student sign & date if 18 years of age or older; Parent/guardian sign & date if student is under 18 years of age.

An official stamp AND an authorized signature from a healthcare provider must appear on this form or it will not be accepted.

_____ _____
Signature and Stamp of health care provider **Date**

_____
Phone number of health care provider