HEBREW UNION COLLEGE – JEWISH INSTITUTE OF RELIGION
היברו יוניון קולג - מכון למדעי היהדות

Student Immunization Record

In order to maintain the health of all students: public health law requires that students attending postsecondary institutions in the state submit proof of immunization against certain vaccine preventable diseases. Hebrew Union College students may demonstrate immunity by presenting proof of having received two (2) vaccinations for Rubeola (Measles), two (2) vaccinations for Mumps, and at least one vaccination for Rubella (German Measles) or if given in combination, two (2) M-M-R (Measles, Mumps and Rubella) vaccines. Immunity may also be affirmed by providing the results of a laboratory test (immune titer) for each disease.

Student's Name	Date of Birth	Campus

Mandatory Immunizations

Two Measles Mumps and Rubella (MMR) vaccinations
- Date 1: Immunization on or after first birthday and after January 1, 1957 — Date_____
- Date 2: Immunization 15 moths after birth and at least 28 days after 1st vaccination — Date_____
- If born **before** 1957, indicate birth date — Date_____

OR

Two Measles (Rubeola) vaccinations
- Date 1: Immunization on or after first birthday and after January 1, 1957 — Date_____
- Date 2: Immunization 15 moths after birth and at least 28 days after 1st vaccination — Date_____
- Date of positive immune titer — Date_____

Rubella (German Measles) vaccination
- Date 1: Immunization on or after first birthday and after January 1, 1957 — Date_____
- Date 2: Immunization 15 moths after birth and at least 28 days after 1st vaccination — Date_____
- Date of positive immune titer — Date_____

Other Vaccines (Recommended by not mandatory for Admission)

Tetanus, Diphtheria, Pertusis (primary series completed) — Date_____
- Last booster (within 10 years) Date_____

Hepatitis A Series First_____ Second_____

Hepatitis B Series First_____ Second_____ Third_____

Varicella (Chicken Pox) Vaccine — Date_____
- Positive immune titer to Varicella — Date_____

OR

Date Varicella was diagnosed — Date_____

Polio (if primary series completed, list the last booster) — Date_____

Tuberculosis skin test — Date_____ Result: □ neg □ pos

If positive, date of chest X-ray — Date_____ Result: □ neg □ pos

If positive, was prophylaxis given? □ yes □ no — Dates: from_____ to_____

Physician Signature	Physician Stamp (office stamp required)
Date	