Important!
Please Do Not Delay – Due June 19th

Checklist for completing
Student Health Center requirements*:

- PRINT, COMPLETE and RETURN pages 1 and 2 of the form below

- Your physician’s office completes and signs the Required and Strongly Recommended Immunizations sections (page 1)
  - Measles, Mumps, Rubella, Meningitis and Tetanus immunizations are required**

- Student/Parent signs and dates the consent and release statements (page 2)

- Ensure all four parts of the form are complete before mailing/faxing/emailing it to the Health Center:
  1. Required Immunizations
  2. Strongly Recommended Immunizations
  3. Physician’s Signature, date, contact information
  4. Consent and Release Signatures

- Remember to complete all four on-line Portal Forms that are found on the Student Health Center Portal:
  1. Patient Information-Medical History form
  2. Notice of Privacy Practices form
  3. Health Insurance Waiver-Enrollment form
  4. Tuberculosis Screening form [TB testing is offered at Health Center]

- If you are playing a varsity sport you will also need to have your physician fill out the physical exam form and submit this documentation before you will be cleared to participate. Students who are not participating in varsity athletics do not need to have a pre-entrance physical.

*Your pre-entrance health requirements are not complete until you submit the paper immunization form (pages 1 & 2 below), the four on-line forms, and the online alcohol and sexual misconduct education programs (new and transfer undergraduates only).

**Vaccines are available at the Student Health Center (fees may apply)
Rensselaer Student Health Center Pre-entrance Immunization Form 2017-2018

Student Information Section – Completed by Student:

<table>
<thead>
<tr>
<th>Last/family Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Gender</th>
<th>Date of Birth (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Cell Phone #</td>
<td>Student Email (for contacting about this form)</td>
<td>RIN# (Rensselaer ID#)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Must be completed by a healthcare professional, in its entirety, in English, prior to Registration.

1. Required Immunizations:  

**PLEASE SUBMIT DATES IN MM/DD/YYYY FORMAT**

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Requirement</th>
<th>Dosage Requirement</th>
<th>Date of Disease</th>
<th>Titer Date</th>
<th>Result</th>
</tr>
</thead>
</table>
| MMR (combined measles, mumps, rubella):  
  - NYS Health Department Law  
    - **TWO** doses required after 1st birthday and at least 28 days apart and after 01/01/1968 | Dose #1: /_____/___  
  Dose #2: /_____/___ |  
| MEASLES (if MMR not given):  
  - NYS Health Department Law  
    - **ONE** of the following is required | Dose #1: /_____/___  
  Dose #2: /_____/___ |
|  - OR Titer (blood test, serology) confirming immunity: ATTACH LAB RESULTS | Titer Date: /___/___ Result: ________ |
| MUMPS (if MMR not given):  
  - Rensselaer Requirement  
    - **ONE** of the following is required  
    - **TWO** doses required after 1st birthday and after 01/01/1968 | Dose #1: /_____/___  
  Dose #2: /_____/___ |
|  - OR Titer (blood test, serology) confirming immunity: ATTACH LAB RESULTS | Titer Date: /___/___ Result: ________ |
| RUBELLA (if MMR not given):  
  - NYS Health Department Law  
    - **ONE** dose required after 1st birthday and after 01/01/1968 | Dose #1: /_____/___  
  Dose #2: /_____/___ |
|  - OR Titer (blood test, serology) confirming immunity: ATTACH LAB RESULTS | Titer Date: /___/___ Result: ________ |
| MENINGITIS (MenACWY or MPSV4) Required for students 34 years old and under:  
  - Booster required if meningitis vaccine received prior to age 16 years | Dose #1: /_____/___  
  Dose #2: /_____/___ |
|  - OR Titer (blood test, serology) confirming immunity: ATTACH LAB RESULTS | Titer Date: /___/___ Result: ________ |
| TETANUS/DIPHTHERIA (DTP, Td, DT, TdAP):  
  - Rensselaer Requirement  
    - Required booster within last 10 years | Type ________  
  Date /___/___ |

2. Strongly Recommended Immunizations: (Not required for registration; All Immunizations except Varicella and Polio are available at the Student Health Center – fees may apply)

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Requirement</th>
<th>Dosage Requirement</th>
<th>Date of Disease</th>
<th>Titer Date</th>
<th>Result</th>
</tr>
</thead>
</table>
| HEPATITIS A  
  Dose #1: /_____/___  
  Dose #2: /_____/___ | Dose #1: /_____/___  
  Dose #2: /_____/___ |  
| HEPATITIS B  
  Dose #1: /_____/___  
  Dose #2: /_____/___  
  Dose #3: /_____/___ | Dose #1: /_____/___  
  Dose #2: /_____/___  
  Dose #3: /_____/___ |  
| GARDASIL  
  Dose #1: /_____/___  
  Dose #2: /_____/___  
  Dose #3: /_____/___ | Dose #1: /_____/___  
  Dose #2: /_____/___ |  
| POLIO (OPV or IPV)  
  Dose #1: /_____/___  
  Dose #2: /_____/___  
  Dose #3: /_____/___  
  Dose #4: /_____/___  
  Dose #5: /_____/___ | Dose #1: /_____/___  
  Dose #2: /_____/___  
  Dose #3: /_____/___  
  Dose #4: /_____/___  
  Dose #5: /_____/___ |  
| MENINGITIS SEROGROUP B  
  Dose #1: /_____/___  
  Dose #2: /_____/___ | Dose #1: /_____/___  
  Dose #2: /_____/___ |  
| VARICELLA (Chicken Pox) Vaccination/Disease  
  Dose #1: /_____/___  
  Dose #2: /_____/___  
  Date of Disease /_____/___  
  Titer: /_____/___ Result: ________ | Dose #1: /_____/___  
  Dose #2: /_____/___ |  
| Return all information to:  
  Student Health Center-RPI  
  110 8th Street- 3200 Academy Hall  
  Troy, NY 12180  
  (518)276-6287 Fax: (518)276-8573  
  healthrecords@rpi.edu | OR |  

3. Healthcare Professional: By signing below, you attest that all information supplied on this form is true & correct to the best of your knowledge.  

Health Care Provider Signature: __________________________ Date: _________  
Health Care Provider’s Name: __________________________ Phone Number: ( ) ________ Fax: ( ) ________  
Address: __________________________  

*Stamp may be used, but must be accompanied by signature and date*  

Page | 1  
Continued onto Page 2
4. Consent and Release:

Your medical information is confidential and will not be released without your written consent. If you are under 18 years of age, your parents may have access to some of the data in your medical and counseling records. They will be notified if you are hospitalized. If you are over 18, it is your responsibility to inform your parents regarding your medical information.

• Read and sign the following release:  
In the event of serious physical or mental illness, I hereby consent to the notification of the person listed below as my emergency contact. I also consent to this information being released to an international health care provider, program director, or exchange program host, if necessary to facilitate medical treatment while I am abroad on an RPI affiliated or non-affiliated study abroad program.

  Emergency Contact: ______________________________ Phone Number(s): __________________________

  Student’s Signature__________________________________________ Date ________________________

• If you are under 18 years of age, the following needs to be signed by your parent/guardian.

  I give permission for my son/daughter to be treated by the Student Health Center including health and counseling services. I also authorize urgent or emergency treatment at Samaritan Hospital in Troy, NY or St. Mary’s Hospital in Troy, NY. Financial coverage for medical care is subject to insurance plan limitations.

  Parent’s/Guardian’s Signature________________________________ Date _______________________

Return all information to:

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Troy, NY 12180
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