MISSISSIPPI STATE UNIVERSITY
IMMUNIZATION
FORM

PLEASE PRINT

Name _____   MSU Id Number _____
        Last   *First*   *M.I.*

Address _____
        Street or P.O. Box   *City*   *State*   *ZIP*

Phone Number (_____) _____ Date of Birth_____

E-mail _____

All students, including transfer and graduate students, born after 1956 are required to provide proof of immunity to RUBEOLA (red measles) and RUBELLA (German measles). Immunity may be demonstrated by one of the following:

• *Documentation (month, day, year) of two MMRs **or** two measles (Rubeola) and two Rubella vaccinations.*
• *Documented history (month, year) of positive measles (Rubeola) and Rubella serologic titer. (Copies of lab results must accompany this form.)*
• *Physician documented history (month, day, and year) of having had measles (Rubeola) and Rubella (attach office records).*

PLEASE COMPLY WITH THIS REQUIREMENT BEFORE YOU COME TO CAMPUS. YOU CANNOT COMPLETE REGISTRATION UNTIL THIS REQUIREMENT HAS BEEN MET. INCOMPLETE FORMS WILL BE RETURNED.

1ST MMR VACCINATION*	2ND MMR VACCINATION*
_____ **MONTH DAY YEAR**	_____ **MONTH DAY YEAR**

RUBEOLA AND RUBELLA VACCINATIONS MAY BE GIVEN INSTEAD OF MMR IMMUNIZATIONS.

VACCINE	1ST VACCINATION	2ND VACCINATION
RUBEOLA*/ (RED MEASLES)**	_____ **MONTH DAY YEAR**	_____ **MONTH DAY YEAR**
RUBELLA*/ (GERMAN MEASLES)**	_____ **MONTH DAY YEAR**	_____ **MONTH DAY YEAR**

In lieu of vaccinations, please provide proof of immunity by checking the appropriate box(es):

☐ Serologic confirmation of immunity to Rubeola (red measles). Copies of lab results must accompany form.
☐ Serologic confirmation of immunity to Rubella (German measles). Copies of lab results must accompany form.
☐ Had Rubeola (red measles). Attach office records.
☐ Had Rubella (German measles). Attach office records.
☐ Medically contraindicated because of pregnancy, allergy to vaccine, immune compromise (HIV), etc. List reasons, EDC, etc.

ALL DOCUMENTATION MUST BE SIGNED BY A PHYSICIAN OR AUTHORIZED HEALTH CARE PROVIDER AND ACCOMPANIED BY AN OFFICE STAMP WITH ADDRESS.

Name of Clinic _____

Address of Clinic _____   **OR**

_____

Signature of Health Care Provider _____

*Not required for females who may be pregnant.
**Reimmunization is necessary when:
• *Rubeola was administered before 12 months of age and/or before January 1, 1968.*
• *Rubella was administered before 12 months of age and/or before January 1, 1969.*
• *MMR vaccine was administered before 12 months of age.*

If you have questions, please call the Immunization Coordinator at 662-325-0706 or e-mail health@saffairs.msstate.edu