DCB Student MMR Immunization Record

Dakota College at Bottineau

The State Board of Higher Education requires that all college and university students provide state institutions with proof of immunization for Measles, Mumps and Rubella (MMR). Such proof can be provided by completing this form or by submitting a photocopy of official medical records. For your convenience, you may wish to check with your high school, present college/university, or local physician/health office to see if you can obtain photocopies of applicable records. If such photocopies are not available, please complete the appropriate items below. Completed information should be sent to the Student Services Office.

Student's Name: _____

Home Address: _____

Home Phone Number: _____

PROOF OF MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION: *The following must be completed and signed by a licensed physician or authorized representative of a state or local health department. Check the appropriate statement and provide the required information and signature:*

❑ Student has had two doses of measles, mumps and rubella vaccine. (First dose must have been given after the age of 12 months.)

Date of first dose _____ **Date of second dose** _____

❑ Student has prior physician-diagnosed MMR disease(s) or laboratory evidence of MMR immunity.

❑ Student was born prior to 1957. (Birth date:_____)

SIGNATURE OF PHYSICIAN OR AUTHORIZED HEALTH OFFICIAL: I certify the statement checked reflects this student's immunization status.

Physician signature _____ date _____

Physician name (please print) _____ Physician address (city/state) _____ phone number _____

EXCEPTIONS: *The following section must be completed and signed by a licensed physician or authorized representative of a state or local health department. Check the appropriate statement and provide the required information and signature:*

❑ Immunization is contraindicated for this student by illness, pregnancy, allergies, or other medical conditions.

❑ This student has had one immunization (date: _____) and agrees to have a second one no less than one month later.

SIGNATURE OF PHYSICIAN OR AUTHORIZED HEALTH OFFICIAL: I certify the statement checked reflects this student's immunization status.

Physician signature _____ date _____

Physician name (please print) _____ Physician address (city/state) _____ phone number _____

OTHER EXCEPTIONS: *Student should check the appropriate statement and sign where indicated.*

❑ My religious beliefs preclude my participation in an immunization program

❑ I am only attending a short term workshop or camp at the University.

Student signature _____ date _____

name (please print) _____ address (city/state) _____ phone number _____

EMERGENCY NOTIFICATION: Specify person to be notified in case of emergency or missing person

Name _____ Relationship _____

Address _____

Telephone (Home) _____ (Work) _____