



Name: _____	A Number: _____
Date of Birth: _____	Phone: _____
Address: _____	

In order to maintain the health and safety of all members of our campus community, Evergreen has adopted the following immunization requirement guideline from recommendations by the US Center for Disease Control, the American College Health Association and state and local Public Health Departments. **This requirement applies to all new undergraduate and graduate students born on or after January 1, 1957. To meet the requirement you need to complete and sign this form and document one of the options below.**

- Option 1: Proof and **SIGNATURE** from a doctor/clinic that you have had 2 measles (rubeola) vaccines since 1969, **OR**
- Option 2: Proof and **SIGNATURE** from a doctor/clinic that you have had the disease of measles (rubeola), **OR**
- Option 3: Proof and **SIGNATURE** from a doctor/clinic that you have a positive measles (rubeola) antibody test, **OR**
- Option 4: For a medical, religious or personal reason, you can sign the Waiver of Immunization on the back of the form.

Option 1 - I have received two doses of MMR or Rubeola Vaccine.

Date of the <u>first</u> immunization: _____	Date of the <u>second</u> immunization: _____
Health Care Provider signature: _____	Health Care Provider signature: _____
Address: _____	Address: _____
Phone: _____	Phone: _____

Option 2 - I have had Rubeola Measles and was diagnosed by my Health Care Provider.

Date of Measles case/diagnosis: _____
Health Care Provider signature: _____ Phone: _____
Address: _____

Option 3 - I have had a blood test (Rubeola Titer), which indicates that I am immune to Rubeola Measles.

Date of blood test: _____
Health Care Provider signature: _____ Phone: _____
Address: _____

I certify that the above statement(s) are accurate and true to the best of my knowledge.

Student's signature: _____

Date: _____

If needed, please complete the Immunization Waiver on the back of this form.

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Measles Immunization Waiver

Option 4:

Due to medical, religious, or personal reasons, I choose to decline immunization. In the event of a measles case or outbreak on campus, I agree to comply with quarantine or isolation procedures as recommended by the Center for Disease Control and Prevention *and* the state and local Health Departments. I understand that this will likely result in missing classes or any other campus activity, including student employment, for the duration of the exposure risk, which would be a minimum of 14 to 21 days.

Student name (printed) _____

Student signature: _____ Date: _____

Please keep a copy of your immunizations for your personal records.

If needed, please complete the Immunization Waiver on the back of this form.