

## Measles Mumps and Rubella (MMR) Documentation Form

Name \_\_\_\_\_ A# \_\_\_\_\_ Date of \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First MI Birth Month Day Year  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

For 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, document one of the options below, and submit to Student Wellness Services or Registration and Records.**

Option 1: Proof and/or **signature** from a doctor/clinic that you have had 2 measles (rubeola) vaccines since 1969, **OR**

Option 2: Proof and/or **signature** from a doctor/clinic that you have had the disease of measles (rubeola), **OR**

Option 3: Proof and/or **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 Measles Immunization Waiver on the back of the form.***

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

Date of the **first** immunization: \_\_\_\_\_ Date of the **second** immunization: \_\_\_\_\_

Health Care Provider signature: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

see attached documents

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

Date of measles case/diagnosis: \_\_\_\_\_

Health Care Provider signature: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

see attached documents

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

Date of blood test: \_\_\_\_\_ Titer Results \_\_\_\_\_

Health Care Provider signature: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

see attached documents

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

**Student signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Measles Immunization Waiver

Name \_\_\_\_\_ A# \_\_\_\_\_ Date of \_\_\_\_\_  
*Last First MI Birth Month Day Year*

Address \_\_\_\_\_ Phone \_\_\_\_\_

### 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.**