Post University Health Services
800 Country Club Road PO Box 2540
Waterbury, CT 06723-2540
Office (203) 596-4503 Fax (203) 841-1179

Please complete the form below and mail or fax to the above address

_____ _____ _____

Last Name First Middle

Date of Birth: ___/___/___ Country of birth _____Email:_____

Address _____ City_____

State_____ Zip _____

Phone H ( )_____W ( )_____ Cell ( )_____

Student Status: ADP_____ Day (Part- Time) _____Graduate Division_____

Students' grades will be held and registration may be delayed unless proper proof is provided.

- ***Laboratory verification of immunity will be accepted if you do not have proper proof of immunizations - laboratory report must be attached. ****

Record of Immunizations

MMR (measles, mumps and rubella) 2 dates are required **or** verification of immunity by a titer

#1 ___/___/___ (on or after your 1st birthday and after 1/1/1957) #2 ___/___/___(must be given after 1/1/1980)

Two dates are required and a minimum interval of 28 days must separate the vaccines

If you have received measles instead of MMR Please indicate:

Measles (Rubeola) # 1 ___/___/___ # 2 ___/___/___ or antibody titer results _____date___/____/____ *

Mumps # 1___/___/___ # 2 ___/___/___ or antibody titer results _____date___/____/____ *

Rubella # 1___/___/___ # 2 ___/___/___ or antibody titer results _____date ___/____/____ *

VARICELLA (chicken pox) 2 dates are required if born after 1/31/1979.

It is not required for students born in the United States **before 1980** but **all foreign born** students must have 2 Vaccines or antibody titer test showing immunity.

#1 ___/___/____ and #2 ___/___/____ or antibody titer results _____date:___/____/___*

or Confirmed natural disease by a physician _____date:___/____/___

Health Care Provider's Name: _____Phone ( )_____

Health Care Provider's Signature: _____ date: ___/____/___

have 2 Vaccines or antibody titer test showing immunity.

#1 ___/___/____ and #2 ___/___/____ or antibody titer results _____date:___/____/___*

or Confirmed natural disease by a physician _____date:___/____/____

Health Care Provider's Name: _(Print)_____Phone ( )_____

Health Care Provider's Signature: _____ date: ___/____/___