ARIZONA STATE UNIVERSITY IMMUNIZATION REQUIREMENT

**Note: Students will not be permitted to register for, add or drop courses without proper submission of their MMR immunization records to the ASU Health Services, Immunization Department.**

Arizona State University policy – SSM 106-01 requires the following from all incoming and transfer students:

- Proof of **TWO MMR** - Measles (Rubeola 10 day Hard Measles), Mumps and Rubella (German measles) vaccinations. The first vaccination is given at or after 1 year of age and the second is commonly given at or after 4-6 years of age. If your records do not reflect this immunization schedule, the two MMR vaccinations must be at least 28 days apart from each administrated date.
  
  **OR**
  
  Proof of a **POSITIVE** titer test that shows immunity to **RUBEOILA** (Hard 10 day Measles).

- At least one MMR vaccination must have been given after **1979**.
- All documents must be in **English** (translated copies will be accepted).
- Students **born before** January 1, 1957 are not subject to this requirement.

ASU Health Services offers MMR vaccinations and **Rubeola** (Hard 10 day measles) titer blood test.

Submit documentation through **mail, email, fax or in person** to ASU Health Services. You may have your health care provider fill out and sign the form below with their official office stamp. Have your health care provider include a copy of the **Rubeola** (Hard 10 day Measles) titer test **if applicable**. You may also personally fill out this form if you include a copy of your MMR vaccination record or a copy of your **Rubeola** (Hard 10 day Measles) titer blood test. Please allow 2 business days for processing. You can check the status of your submitted documents by checking your MyASU. If the hold has been removed from your MyHolds, then the data has been successfully uploaded.

**Note: we do not keep copies of your immunization records.**

**HIGHLY RECOMMENDED IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date of Immunization</th>
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</thead>
<tbody>
<tr>
<td>Meningitis</td>
<td>/ / (MM) (DD) (YYYY)</td>
</tr>
<tr>
<td>Tetanus/TDAP</td>
<td>/ / (MM) (DD) (YYYY)</td>
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Health Care Provider Signature / Stamp ____________________________

Date __________

Date of MMR #1 ___/____/_____      Date of MMR #2 ___/____/_____

(MM) (DD) (YYYY)                                                   (MM) (DD) (YYYY)

OR Date of titer test ____/____/_____  

(MM) (DD) (YYYY)

Last Name                                                            First Name, Middle Initial                                      Date of Birth (MM/DD/YYYY)

Phone Number                                                        University ID# (10 digits)                             Email Address