ARIZONA STATE UNIVERSITY IMMUNIZATION REQUIREMENT

IMMUNIZATION DEPARTMENT
ASU Health Services
Arizona State University
P.O. Box 872104
Tempe, AZ 85287-2104

PHONE: 480-965-8177
FAX: 480-965-8914
EMAIL: measles@asu.edu

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

- Proof of TWO MMR – Measles, Mumps and Rubella 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. Note: The first MMR must be at or after 1 year of age.
  OR
  Proof of a POSITIVE titer test that shows immunity to RUBEOLA or MMR.
- 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.

You may personally fill out this form without provider signature if you include a copy of your vaccination record or a copy of your Rubeola or MMR titer blood test.

Don’t have a copy of your records?
A. You may have your healthcare provider fill out the needed information and sign/stamp the form below.
  OR
B. Schedule an appointment with ASU Health Services for MMR vaccinations or lab test for RUBEOLA.
   For appointments please call (480) 965-3349

Please allow time for processing. Check your status by logging on to MyASU, Priority Tasks. If you do not see a hold for MMR’s then you have been cleared.

Date of MMR #1 ____/____/____(after 1st year of birth)  Date of MMR #2 ____/____/____
  (MM) (DD) (YYYY)  (MM) (DD) (YYYY)

OR Date of Rubeola or MMR titer test ____/____/____
  (MM) (DD) (YYYY)

HIGHERLY RECOMMENDED IMMUNIZATIONS

Meningitis (Most recent) ____/____/____  Tetanus/TDAP ____/____/____
  (MM) (DD) (YYYY)  (MM) (DD) (YYYY)

Health Care Provider Signature / Stamp __________________________ Date __________
(Signature of provider is not necessary if a copy of vaccination records is attached.)

Student's Information: Last Name __________________________ First Name, Middle Initial __________________________ Date of Birth (MM/DD/YYYY)

University ID# (10 digits) __________ Phone Number __________ Email Address __________

5/28/15