



Immunization Policy & Forms

Offices of the Registrar and Rector

33 Prospect Hill Road · Cromwell, Connecticut 06416 / Tel. (860) 632-3010 · Fax: (860) 632-3030 / registrar@holypostles.edu

POLICY

Connecticut State Law requires that all full-time or matriculated¹ students (enrolled in a degree or certificate program) in institutions of higher education provide adequate proof of immunization against Measles, Mumps and Rubella (MMR). The same also applies to immunization against Varicella (chicken pox).

The law requires that if you were born after December 31, 1956 you must present certification of MMR immunization prior to registering for classes unless one or more exemptions apply (see forms for list of applicable exemptions). With respect to immunization against Varicella (chicken pox), unless you were born in the United States before January 1, 1980, you must present certification of Varicella immunization prior to registering for classes unless one or more exemptions apply (see forms for list of applicable exemptions).

For Seminarians, in addition to the above, Connecticut State law requires that any college or university student under 29 years of age residing in on-campus housing be vaccinated against meningitis. Seminarians at Holy Apostles who have not submitted verification or an exemption form will not be permitted to check into on-campus housing.

Non-Seminarian Students: COMPLETED FORMS MUST BE RETURNED TO THE **OFFICE OF THE REGISTRAR** *PRIOR TO REGISTRATION*
Seminarian Students: COMPLETED FORMS MUST BE RETURNED TO THE **RECTOR'S OFFICE** *PRIOR TO REGISTRATION*

¹ Matriculated students are defined as those enrolled in a degree-seeking (or certificate-seeking) program. (State of Connecticut, Department of Public Health, Memo dated April 26, 2010 entitled: New College Immunization Requirements—Clarification Update). Part-time non-matriculated students are **not required** to have MMR and varicella immunizations although they are **recommended** to have those vaccines by the Advisory Committee for Immunization Practices (Ibid.)



Exemption from Immunization Requirements

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Exemption to Immunization Requirements Form

Name (Last, First, MI)	
Date of Birth	ID #
Home Address	Campus Telephone
Home Telephone	
Date Entering Holy Apostles	Date Expected Graduation
Exempt immunization/Testing (Check all that apply)	
<input type="checkbox"/> Measles <input type="checkbox"/> Rubella <input type="checkbox"/> Mumps <input type="checkbox"/> Varicella <input type="checkbox"/> Meningitis	

**Statement of Exemption to Immunization Law
Medical Exemption**

The physical condition of the above named individual is such that (___ measles ___ mumps ___ rubella ___ varicella) immunization would endanger life or health.

State reasons for requesting a medical exemption:

Healthcare Provider Signature

Date

**Statement of Exemption to Immunization Law
Religious Exemption**

(Includes a strong moral or ethical conviction similar to a religious belief)

The above named individual adheres to a religious belief whose teachings are opposed to (___ measles ___ mumps ___ rubella ___ varicella) immunizations.

Signed: _____ Date: _____

**Statement of Exemption to Meningitis Immunization Law
Age Exemption**

I am 29 years of age or older and choose not to receive the vaccination.

Signed: _____ Date: _____

I understand that exemption for either medical, religious or age reasons subjects me to exclusion from campus in the event of an outbreak of a disease for which immunization is required.

Signed: _____ Date: _____

Holy Apostles' Immunization Form (page 1 of 3)

(Please print neatly or type)

Name of Student: _____

(last, first, middle)

Student's Address: _____

(street, city/town, zip code)

Phone #:(_____)_____

Student ID # or Social Security#: _____

Student's Date of Birth: _____

Choose an appropriate option for each of the 5 diseases (Measles, Mumps, Rubella, Varicella, Meningitis).

EXEMPTIONS (completed by student)

STUDENTS CLAIMING ANY EXEMPTION BELOW THAT IS MARKED WITH AN ASTERISK (“*”) MUST ALSO COMPLETE AND SUBMIT THE ATTACHED “EXEMPTION TO IMMUNIZATION REQUIREMENTS” FORM

STUDENTS CLAIMING ANY EXEMPTION BELOW THAT IS MARKED WITH A DOUBLE ASTERISK (“**”) MUST ALSO COMPLETE AND SUBMIT THE ATTACHED “EXEMPTION TO IMMUNIZATION REQUIREMENTS” FORM

I am exempt from the Measles, Mumps and Rubella (MMR) immunization requirements immunization requirement for the following reason(s):

_____ I was born on or before December 31, 1956

_____ Laboratory confirmation of immunity to such diseases** (Holy Apostles' Immunization Form, p. 2, Option 2).

_____ Documentation from a physician stating that the student is medically contraindicated from receiving such vaccine*

_____ Documentation from the student that such an immunization is contrary to his/her religious beliefs*

_____ Documentation from a physician or director of health that the student has had a confirmed case of the disease** (Holy Apostles' Immunization Form, p. 2, Option 3)

_____ Enrollment in the distance-learning program only

I am exempt from the varicella immunization requirements immunization requirement for the following reason(s):

_____ I was born in the United States before January 1, 1980

_____ Laboratory confirmation of immunity to such diseases ** (Holy Apostles' Immunization Form, p. 2, Option 2).

_____ Documentation from a physician stating that the student is medically contraindicated from receiving such vaccine*

_____ Documentation from the student that such an immunization is contrary to his/her religious beliefs*

_____ Documentation from a physician or director of health that the student has had a confirmed case of the disease** (Holy Apostles' Immunization Form, p. 2, Option 3)

_____ Enrollment in the distance-learning program only

FOR STUDENTS RESIDING ON CAMPUS:

_____ I am over the age of 29 years and claim exemption from the meningitis vaccination requirement*

Student's Signature_____

Date_____

Holy Apostles' Immunization Form (page 2 of 3)

Name of Student _____

Social Security # or Student ID # _____

COMPLIANCY REQUIREMENTS TO BE COMPLETED BY *PHYSICIAN ONLY*

OPTION 1

MMR 1st dose _____ / _____ / _____ 2nd dose _____ / _____ / _____

(First dose on or after the first birthday and given on or after January 1, 1969. Second dose must be on or after January 1, 1980.)

OR

Measles 1st dose _____ / _____ / _____ 2nd dose _____ / _____ / _____

(First dose on or after the first birthday and given on or after January 1, 1969. Second dose must be on or after January 1, 1980.)

AND

AND

Varicella (Chicken Pox) 1st dose _____ / _____ / _____ 2nd dose _____ / _____ / _____

(If first dose was before 13 years of age, i.e. age 12 or under, then only one dose is required. If first dose was

OPTION 2

Laboratory titers (blood test) with attached copies of the lab reports dated _____ showing positive immunity results for:

OPTION 3

Confirmation of disease (date) _____

Physician's Name and Stamp (please type or print) _____
Date _____

Physician's
Address _____

Physician's
Signature _____ Telephone _____

Holy Apostles' Immunization Form (page 3 of 3)

Name of Student _____

Social Security # or Student ID # _____

ALL INCOMING SEMINARIANS MUST COMPLETE AND RETURN THIS FORM TO THE RECTOR'S OFFICE

STUDENTS CLAIMING AN EXEMPTION MUST ALSO COMPLETE AND SUBMIT THE ATTACHED "EXEMPTION TO IMMUNIZATION REQUIREMENTS" FORM

Meningitis vaccination is required by law only if living on the Holy Apostles' campus and you are less than 29 years of age.

- I will not be living in housing owned by Holy Apostles. I do not require this vaccine.
- I will be 29 years of age at the time entering Holy Apostles. I do not require this vaccine.

COMPLETE THE FOLLOWING ONLY IF NOT CLAIMING ONE OF THE ABOVE EXEMPTIONS

The date of meningococcal (meningitis) vaccination must cover your enrollment at Holy Apostles.

COMPLIANCY REQUIREMENTS BELOW TO BE COMPLETED *BY PHYSICIAN ONLY*

Meningococcal (Check vaccine type):

- Menactra (Effective for 10 years) OR
- Menomune (Effective for 5 years)

Date of Vaccination:

Physician's Name and Stamp (please type or print) _____

Date _____

Physician's Address _____

Physician's
Signature _____ Telephone _____