

# Suffolk County Community College

## Medical Exemption from Immunization Requirements

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_____	_____	_____	_____
Last Name	First Name	MI	College ID/SS#
Address _____			
_____	_____	_____	_____
City	State	Zip	

**Directions:**

In order to qualify for a medical exemption from immunization requirements as specified by Section 2165 of the New York State Public Health Law, your physician must complete this exemption form and the completed form must be returned to the Health Services Office on your home campus.

You should also bring your health records to the Health Services Office in order to document any previous immunizations, a physician-verified diagnosis of measles or mumps disease, and/or positive titer results. Note that the titer is a blood test, which determines the level of immunity an individual may have to measles, mumps or rubella, and may be used as an alternative to immunizations.

If an outbreak of measles, mumps or rubella should occur on campus, you will be considered susceptible under New York State Public Health Law and may be required to remain off campus until the Suffolk County Department of Health deems it safe for you to return. These absences may cause you to be withdrawn from your classes. Immunization records or titer results may fulfill the immunization requirements and prevent exclusion from the campus in the event of an outbreak.

**Student Certification:**

This is to certify that I have read and understand the above information.

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_____	_____
Student's Signature	Date

**To be Completed by Physician:**

Immunizations from which student is to be exempted:

Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent condition: Student is exempt from immunizations permanently.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary condition: Date immunizations may be administered: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy with EDC _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Trying to conceive _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Other: _____	

This form will not be accepted without both physician's signature and stamp.

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_____	_____
Physician's Signature	Physician's Stamp
_____	_____
Date	

**Return to:**

<b>Health Services Office Ammerman Campus</b> 533 College Road Robert T. Kreiling Hall, Room M106 Selden NY 11784-2899 Phone: (631) 451-4047 Fax: (631) 451-4874	<b>Health Services Office Eastern Campus</b> 121 Speonk-Riverhead Road Peconic Building, Room P115 Riverhead NY 11901-3499 Phone: (631) 548-2510 Fax: (631) 548-2504	<b>Health Services Office Grant Campus</b> Crooked Hill Road Captree Commons, Room C105 Brentwood NY 11717-1092 Phone: (631) 851-6709 Fax: (631) 851-6820
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