



# MMM IMMUNITY REQUIREMENT

**COVID** vaccination documents must be submitted at <https://uw.edu/studentcovidform>

This immunization form can be used in place of complete immunization records for the MMM (Measles, Mumps, and Meningococcal ACWY) requirement, but **a signed form is not required if you submit official records**. A medical professional **must** fill out the bottom portion of this form to verify your required immunizations, and initial/date any changes, if you are not submitting official records of all required vaccines.

For more information, including accepted vaccine brands, please refer to our website at [immunity.washington.edu](http://immunity.washington.edu). To contact us, please email [immunity@uw.edu](mailto:immunity@uw.edu) or call (206) 616-4672. Faxes are accepted at (206) 543-4928.

**Official Name (last, first):** \_\_\_\_\_

**Date of Birth (Month/Day/Year):** \_\_\_\_\_

**Student UW email address:** \_\_\_\_\_ @uw.edu      **Student ID #:** \_\_\_\_\_

Required Immunizations	Immunization Dates		
<b>MMR</b> 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW	DATE #1 (GIVEN ON OR AFTER 12 MONTHS OF AGE)		DATE #2 (GIVEN 28 DAYS OR MORE AFTER DOSE 1)
<b>-----OR-----</b>			
<b>Measles (Rubeola)</b> 2 DOSES REQUIRED FOR ALL STUDENTS BORN AFTER 1956	DATE #1	DATE #2	OR LABORATORY EVIDENCE OF IMMUNITY <b>SUBMIT REPORT</b> (REVACCINATE FOR EQUIVOCAL TITER)
<b>Mumps</b> 2 DOSES REQUIRED FOR ALL STUDENTS REGARDLESS OF AGE	DATE #1	DATE #2	OR LABORATORY EVIDENCE OF IMMUNITY <b>SUBMIT REPORT</b> (REVACCINATE FOR EQUIVOCAL TITER)
<i>Note: Rubella is NOT required</i>			
<b>AND if 16-21 years old</b>			
<b>Meningitis (ACWY)</b> 1 DOSE CONJUGATE MENINGOCOCCAL ACWY REQUIRED <b>AFTER AGE 15</b> FOR ALL STUDENTS UNDER AGE 22. VACCINES FROM CHINA NOT CURRENTLY ACCEPTED.	DATE #1 (AND BRAND, IF KNOWN)		DATE #2 (AND BRAND, IF KNOWN)—ONLY REQUIRED IF DOSE 1 WAS TAKEN UNDER AGE 15
<i>Note: Meningococcal B is recommended but DOES NOT fulfill this requirement.</i>			

Health Care Professional Verification of Accuracy – Students may not sign their own forms.	
<b>Signature of Licensed Health Care Professional</b> Authorized: CLT, DO, MD, NP, ND, PA, RN, RN-C, RPh	<b>Date of signature</b>
<b>Professional Name (print) and License #</b>	<b>Address and Phone Number OR Office Stamp</b>