Immunization Record
for International Students

StarID: ________________ OR Tech ID: ________________

Name: ____________________________________________

Minnesota Law (M.S. 135A.14) requires proof that all students born after 1956 are vaccinated against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions (see below). Any non-exempt student who fails to submit the required information within 45 days after first enrollment cannot remain enrolled. This form is designed to provide the school with the information required by the law and will be available for review by the Minnesota Department of Health and the local health agency.

International students please complete and send this form to Saint Paul College F-1 International Student Advisor by mail or scan and send by e-mail to international@saintpaul.edu.

Enter the dates of each vaccination below. Your booster for diphtheria and tetanus must be within the last 10 years. Your last dose for measles, mumps and rubella must have been after 12 months of age.

<table>
<thead>
<tr>
<th>Measles/Mumps/Rubella MMR (at least one dose required at or after 12 months of age)</th>
<th>Mo/Day/Yr</th>
<th>Mo/Day/Yr</th>
<th>Mo/Day/Yr</th>
<th>Mo/Day/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus/Diphtheria TD (at least one dose required within past 10 years)</td>
<td>Mo/Day/Yr</td>
<td>Mo/Day/Yr</td>
<td>Mo/Day/Yr</td>
<td>Mo/Day/Yr</td>
</tr>
</tbody>
</table>

I certify that the above information is a true and accurate statement of the dates on which I was vaccinated.

Student’s Signature: ____________________________ Date: ________________

OTHER EXEMPTION(S)

Medical Exemption: Students who proclaim a medical exemption to any of the required immunizations must complete because he/she: (Check all that apply and fill in the appropriate blanks.)

- ☐ has a medical problem that precludes the __________________________ vaccine
- ☐ has not been immunized because of a history of __________________________ disease
- ☐ has laboratory evidence of immunity against __________________________ disease

Physician’s Signature: ____________________________ Date: ________________

Conscientious Exemption: I hereby certify by notarization that immunization against __________________________ disease is contrary to my conscientiously held beliefs.

Student’s Signature: ____________________________ Date: ________________

Subscribed and sworn to before me this __________ day of ________, 20__________.

Signature: __________________________________________