Hartford International
UNIVERSITY FOR RELIGION & PEACE

Assistant Dean of Student Experience
Email: ndiaz@hartfordinternational.edu

GRADUATE PROGRAM - IMMUNIZATION VERIFICATION FORM

Connecticut State Law requires that all students born after December 31, 1956 and enrolled in post-secondary schools be protected against measles, rubella, mumps and varicella and show proof of that protection. Additionally, enrolled students living on-campus are required to be immunized against meningitis. HIU policy requires that all students attending courses on campus be fully vaccinated against COVID-19. This form must be completed before registering for classes as a matriculated student.

This form must be completed by either a physician or someone operating under the direction of a physician, i.e. nurse, physician's assistant, nurse practitioner.

Student Name (Last, First, MI)	**Date of Birth**	**Country of Birth**
Physician's Name / Address		**Physician Phone #**

	1st Dose	**2nd Dose**	**OR**
Measles 2 doses or documented immunity. Dose #1 on or after first birthday. Dose #2 at least 30 days after the 1st dose and after 1/1/80	____/____/____ Month/Day/Year Must be on or after the first birthday.	____/____/____ Month/Day/Year Must be at least 30 days after the first dose and after 1/1/80.	☐ Positive titer report attached or history of a confirmed case of the disease.
Rubella 2 doses or documented immunity.	____/____/____ Month/Day/Year	____/____/____ Month/Day/Year	☐ Positive titer report attached or history of a confirmed case of the disease.
Mumps 2 doses or documented immunity.	____/____/____ Month/Day/Year	____/____/____ Month/Day/Year	☐ Positive titer report attached or history of a confirmed case of the disease.
Varicella 2 doses or documented immunity required of students born after 1/1/1980 or born outside the United States.	____/____/____ Month/Day/Year	____/____/____ Month/Day/Year	☐ Positive titer report attached or history of a confirmed case of the disease.
Meningitis 1 dose, given within past 5 years, required of students living on campus.	____/____/____ Month/Day/Year		
COVID-19 Dose number dependent on manufacturer requirement guidelines.	____/____/____ Month/Day/Year MFR:_____	___/____/____ Month/Day/Year MFR:_____	

I hereby certify that this student has received the required immunization(s) or has laboratory evidence of immunity as indicated.

_____ _____

Signature of Physician or Person Authorized by Physician to sign — Date