Middlebury

Request for Provisional Admittance

Dear Student,

Prior to college entry, Vermont's Immunization Rule requires that students have certain immunizations. Exemptions exist for medical or religious reasons. Students are allowed provisional admittance temporarily IF the student has an appointment scheduled to receive the missing vaccine(s), consistent with the Centers for Disease Control and Prevention (CDC) immunization schedule. **Please bring this form to your health care provider for completion (IF provisional admittance is requested). Please upload this completed form with your current Immunization record. International students who are unable to obtain certain vaccinations in their home country can contact Health Services at 802-443-3290 or at healthservices@middlebury.edu for guidance. International students who are unable to obtain required Immunizations in their home country, can indicate a "scheduled appointment" on arrival date at Middlebury.**

_________________________________ __________________ ____________________

Student first/last name | Date of Birth | MC ID#

Failure to comply with the Immunization Rules will result in exclusion from Middlebury College on 8/1/2022.

The student named above is in the process of completing vaccine requirements. Vaccination Appointment(s) scheduled as follows:

Vaccines scheduled:

Vaccine	Dose(s) Missing	Scheduled appointments
Hepatitis B	1 2 3	(mm/dd/yy) ____/____/____(mm/dd/yy) ____/____/____
Measles, Mumps, Rubella (MMR)	1 2	(mm/dd/yy) ____/____/____
Varicella (Chicken Pox) (*Or documentation of disease*)	1 2	(mm/dd/yy) ____/____/____
Meningococcal (A,C,W,Y) *(dose required after age 16 yo)*	1	(mm/dd/yy) ____/____/____
Tdap within 10 years *(one dose after completion of childhood series, then Td or Tdap within 10 years)*	1	(mm/dd/yy) ____/____/____

Upon vaccination, the student will be provided documentation and advised to submit the updated immunization record by uploading to the student health portal.

______________________________ ______________________________

Print Name of Health Care Provider | Signature of Health Care Provider

Date: ___/___/___ | Phone:___________________

Updated 3 18 22 srobinson