



PART 1 - STUDENT IMMUNIZATION RECORD FORM (To be filled out by Health Practitioner)

NAME: _____
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

N.Y.S. Public Health Law § 2165 requires post-secondary students to show protection against measles, mumps and rubella. Persons born prior to January 1, 1957 are exempt from this requirement.

REQUIRED: Measles (Rubeola) Immunity - Must have **one** of the following:

1. **TWO dates of Measles Immunization:** (1) ___/___/___ (2) ___/___/___

Both must be given after 1967 AND the first after the first birthday and the second on or after 15 months of age.

OR

2. Date of Measles Titer ___/___/___ Results: _____(include test copies)

OR

3. Date of physician diagnosed measles disease: ___/___/___

AND signature of the diagnosing physician: _____

REQUIRED: Rubella (German Measles) Immunity - Must have **one** of the following:

1. Date of at least one rubella immunization: (1) ___/___/___ (2) ___/___/___

Must be on or after the first birthday.

2. Date of Rubella Titer _____ Result: _____(include test copies)

Physician diagnosis is **not** acceptable.

REQUIRED: Mumps Immunity - Must have **one** of the following:

1. Date of at least one mumps immunization: (1) ___/___/___ (2) ___/___/___

Must be on or after the first birthday.

2. Date of Mumps Titer _____ Result _____(include test copies)

3. Date of physician diagnosed mumps disease _____ AND
signature of diagnosing physician _____

OR MMR Vaccination:

1. Date - ___/___/___ 2. Date - ___/___/___

PLEASE NOTE : MMR vaccine is recommended for all measles vaccine doses to provided to provide increased protection against all three vaccine-preventable diseases: measles, mumps and rubella.

Physicians Signature

Physicians Address

PART 2 - To be filled out by student.

MANDATORY MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law §2167 mandates that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form.

Check one box and sign below.

I have:

had the meningococcal meningitis immunization within the past 10 years.
Menomune- Date received _____ or Menactra- Date received _____

read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine.

Print Student's name _____ Student Signature _____ Date _____

Student SS # _____ Date of Birth ___/___/___