Student's Name ______________________________ STUDENT ID#______________________________

Student's Date of Birth______________________________

Persons born before January, 1957, are exempt from this requirement and do not need to submit this form.

All Commuter and Resident students MUST have Sections A and E OR Sections B, C, D, and E

Completed in order to be in compliance with the NY State Public Health Laws.

Month / Day / Year

A: M.M.R. (Measles, Mumps, Rubella) If given instead of individual immunization

1st Dose: Immunized on or after first birthday, AND on or after January 1, 1972 ____/____/____

2nd Dose: Immunized 15 months after birth or later, AND at least 28 days after 1st dose. ____/____/____

B: MEASLES (RUBEOLA)

1. ____ History of Illness documented by Health Care Provider ____/____/____
2. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
3. ____ Dose 1: Immunized on or after first birthday, AND on or after January 1,1968 ____/____/___

AND

Dose 2: Immunized 15 months after birth or later AND at least 28 days after 1st dose. ____/____/____

C: MUMPS

1. ____ History of Illness documented by Health Care Provider ____/____/____
2. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
3. ____ Immunized on or after first birthday, AND on or after January 1,1968 ____/____/____

D: RUBELLA (GERMAN MEASLES)

1. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
2. ____ Immunized on or after first birthday, AND on or after January 1,1968 ____/____/____

E: MENINGOCOCCAL MENINGITIS - Required for ALL Students

Check one box.

o Had the meningitis immunization (Menomune™/Menactra™) within the past 10 years. ____/____/____

o Read or have explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

F. STRONGLY RECOMMENDED FOR RESIDENT STUDENTS

_____ PPD Result ____________ ____/____/____

_____ Tetanus or TD (within 10 years) ____/____/____

_____ Polio Series Completes ____/____/____

_____ Hepatitis #1 ____/____/____

#2 ____/____/____

#3 ____/____/____

____ Varicella (If No History of the Chicken Pox) ____/____/____

Physician's Signature ______________________________ Date: ______________

Physician/Provider Stamp & Lic. #______________________________