Immunization Form

Immunization records must be submitted to the Office of Academic Services completed and signed by health care provider or attach immunization records from previous school, health care provider or government agency. ***Students cannot register for classes until they have fulfilled the immunization and meningitis information requirements.***

Name (please print): _____ Social Security #: _____
Last First MI

Birthdate: ____/____/____ Preferred phone: _____
Month Day Year

Part I: MMR (Measles, Mumps, Rubella) REQUIRED

As mandated by New York State Public Health Law §2165, proof is required if born on or after January 1, 1957.

Vaccination	Vaccine Date (Month/Day/Year)	*Or* Serology Results/Date
2 MMR's (combo measles, mumps & rubella vaccine) 1st dose after 1st birthday; 2nd dose at least 28 days later. **OR list individual vaccines below**	#1	
	#2	
2 MEASLES 1st dose after 1st birthday; 2nd dose at least 28 days later	#1	
	#2	Attach lab results &/or note if immune
1 MUMPS after 1st birthday		Attach lab results &/or note if immune
1 RUBELLA after 1st birthday		Attach lab results &/or note if immune

Part II: MENINGITIS INFORMATION FORM REQUIRED

New York State Public Health Law §2167 requires students to learn about Meningitis and be aware of the availability of the meningitis vaccine (available at a cost from your health care provider). While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis at www.health.ny.gov to consider immunization.

Mark one of the statements below and provide your signature:

☐ I have received the immunization for meningitis within the past 10 years.
Date received: _____

☐ I acknowledge the risks associated with meningitis and refuse immunization.

_____ _____
Student Signature Date

Part III: RECOMMENDED (OPTIONAL) VACCINATION

Vaccines listed below are not required for students, but they are recommended.

Vaccination	Vaccine Date(s) (Month/Day/Year)
Meningococcal Meningitis	Circle Menomune Menactra Menveo mcv4 1. 2.

_____ _____
Signature/Stamp of health care provider **Date**

_____
Phone number of practice

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