



STUDENT IMMUNIZATION RECORD FORM

Name: _____ Date of Birth: _____ ID #: _____

Semester Entering LIM: _____ E-Mail Address: _____

PART I: MENINGOCOCCAL MENINGITIS RESPONSE: New York State Public Health Law §2167 (CHECK ONE BOX ONLY)

[] Meningitis Vaccine Date _____

[NOTE: If you (your child) received the meningococcal vaccine Menomune™ (available before February 2005), please note this vaccine’s protection lasts for approximately three to five years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within three to five years after receiving Menomune™.]

[] I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____ (student or parent/guardian for students under age 18)

PART II: PROOF OF MEASLES, MUMPS, AND RUBELLA IMMUNITY: New York State Public Health Law §2165

MEASLES: Two vaccines at least 30 days apart, and on or after one year of age; or blood titer showing immunity; or statement from diagnosing physician that student has had the disease.

MUMPS: One mumps vaccine on or after one year of age; or blood titer showing immunity; or statement from diagnosing physician that student has had the disease.

RUBELLA: One rubella vaccine on or after one year of age; or blood titer showing immunity.

*Those with a birth date prior to January 1, 1957 are exempt from this requirement, but must complete Part I of this form. You must also submit a copy of either a birth certificate or a driver’s license to document your birth date.

A. MMR (Measles, Mumps, and Rubella combined vaccine):

TWO DATES OF MMR VACCINATION: _____ and _____

OR If Measles, Mumps, and Rubella are given as individual vaccines:

B. Measles Immunity – Complete ONE of the following:

1. TWO DATES OF MEASLES VACCINATION: _____ and _____

2. DATE OF MEASLES TITER: _____ Results: _____ (Please provide a copy of the lab report if immunity is by blood titer)

C. Mumps Immunity – Complete ONE of the following:

1. DATE OF MUMPS VACCINATION: _____

2. DATE OF MUMPS TITER: _____ Results: _____ (Please provide a copy of the lab report if immunity is by blood titer)

D. Rubella Immunity – Complete ONE of the following:

1. DATE OF RUBELLA VACCINATION: _____

2. DATE OF RUBELLA TITER: _____ Results:- _____ (Please provide a copy of the lab report, physician diagnosis is NOT acceptable)

PLEASE NOTE: THIS FORM WILL NOT BE ACCEPTED IF THIS SECTION IS NOT COMPLETED

Healthcare Provider Name: _____ License #: _____

Signature/Stamp: _____ Date: _____ Tel: _____