



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**

1<sup>st</sup> Dose: Immunized on or after first birthday, AND on or after January 1, 1972 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

2<sup>nd</sup> Dose: Immunized 15 months after birth or later, AND at least 28 days after 1<sup>st</sup> dose. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**B: MEASLES (RUBEOLA)**

1. \_\_\_\_ Had the disease, confirmed by office record \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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 1<sup>st</sup> dose. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**C: MUMPS**

1. \_\_\_\_ Had the disease, confirmed by office record \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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 Resident Students**

**Check one box.**

Had the meningitis immunization (Menomune™/Menactra™) within the past 5 years. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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 (my child) 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) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_