CERTIFICATE OF IMMUNIZATION

Name____ Birth Date_________/___________/__________

Address____ Res Hall Student Y or N (circle one)

Phone No. (_____)_____________________________ SS#/ID#________________________________

New York Public Health Law requires all students born after 1956 and enrolling for 6 credit hours or more to prove immunity to measles, mumps, and rubella. All immunizations must be administered after 1967, on or after the first birthday, and a minimum of 30 days apart. Exceptions to this requirement will be made for students with genuine and sincere religious beliefs contrary to immunization or for those whom immunizations are medically contraindicated.

Proof of Immunity

2 measles, 1 mumps and 1 rubella immunization OR serology demonstrating proof of immunity to measles, mumps and rubella, OR history of disease (must have date) for measles and mumps signed by a physician. History of rubella is not acceptable.

MANDATORY:

IMMUNIZATIONS **OR** **SEROLOGY**

MMR date 1 ________________ date 2 _______________

Measles date 1_______________ date 2 _______________

Mumps date ________________ Rubella date______________

Measles date_______________ result________________

Mumps date________________ result_______________

Rubella date________________ result________________

HISTORY OF DISEASE please list date of illness

( ) Measles _____________________ ( ) Mumps ______________________

Signature of Physician____

MENINGITIS

*Meningitis Vaccination Date_______________________ **OR**

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 or my child (if under 18 yrs of age) will not obtain the immunization against the meningitis disease.

Signature____ Date_________________________________

***New York Public Health Law requires all college students enrolled for 6 credit hours or more be provided with information on meningitis and the meningitis vaccine and either provide proof of receiving the meningitis vaccine within the last 10 years or decline the immunization.**

RECOMMENDED:

Tetanus Date __________________ (within 10 years)

Hepatitis B Date #1 ________________ Date #2 _______________Date #3 _______________ or Serology Date ____________ Result ________

Tuberculosis (PPD) Date ________________ Result _______ X-Ray Date (if positive) ______________ Result __________

Varicella Vaccine Date ______________ Disease Date ______________ or Serology Date _______________ Result __________

SIGNATURE OF HEALTH CARE PROVIDER completing form:

____ Date ________________________

This form must be completed and returned to Health Services or students will be restricted from future registration or receiving of grades.