



## 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 \_\_\_\_\_ result \_\_\_\_\_

Measles date 1 \_\_\_\_\_ date 2 \_\_\_\_\_

Mumps date \_\_\_\_\_ result \_\_\_\_\_

Mumps date \_\_\_\_\_ Rubella date \_\_\_\_\_

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.



Today's Date \_\_\_\_\_

**HEALTH HISTORY**

Year entering college \_\_\_\_\_  Fall  Spring  Summer

STUDENT (Please fill out this section)

STUDENT ID#/SOC. SEC. NO. \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
last first middle initial

ADDRESS: \_\_\_\_\_ RESIDENTIAL HALL STUDENT:  YES  NO  
street city state zip code

PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ E-MAIL \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
street city state zip code

**EMERGENCY NOTIFICATION**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ OFFICE PHONE: \_\_\_\_\_

INSURANCE CARRIER & ID NUMBER: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

Please X below if you have had or are currently under treatment for any of the following: (Please explain all X's marked below):

- |                         |                          |                      |                          |                              |                          |
|-------------------------|--------------------------|----------------------|--------------------------|------------------------------|--------------------------|
| Alcoholism              | <input type="checkbox"/> | Diabetes             | <input type="checkbox"/> | Migraine Headaches           | <input type="checkbox"/> |
| Anemia                  | <input type="checkbox"/> | Emphysema            | <input type="checkbox"/> | Multiple Sclerosis           | <input type="checkbox"/> |
| Anorexia                | <input type="checkbox"/> | Emotional Problems   | <input type="checkbox"/> | Muscular Dystrophy           | <input type="checkbox"/> |
| Arthritis               | <input type="checkbox"/> | Epilepsy             | <input type="checkbox"/> | More than 20lbs. Overweight  | <input type="checkbox"/> |
| Asthma                  | <input type="checkbox"/> | Gall Bladder Disease | <input type="checkbox"/> | Peptic Ulcer                 | <input type="checkbox"/> |
| Back Disorder           | <input type="checkbox"/> | GERD                 | <input type="checkbox"/> | Seizures                     | <input type="checkbox"/> |
| Bronchitis, Chronic     | <input type="checkbox"/> | Hearing Impaired     | <input type="checkbox"/> | Severe Cramps (Menstrual)    | <input type="checkbox"/> |
| Bulimia                 | <input type="checkbox"/> | Heart Disease        | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> |
| Cancer                  | <input type="checkbox"/> | Hepatitis            | <input type="checkbox"/> | Skin Disorders               | <input type="checkbox"/> |
| Cerebral Palsy (CP)     | <input type="checkbox"/> | High Blood Pressure  | <input type="checkbox"/> | Thyroid Disease              | <input type="checkbox"/> |
| Colitis/Irritable Bowel | <input type="checkbox"/> | Hypoglycemia         | <input type="checkbox"/> | Tuberculosis                 | <input type="checkbox"/> |
| Deafness                | <input type="checkbox"/> | Kidney Disorder      | <input type="checkbox"/> | Visually Impaired            | <input type="checkbox"/> |
| Depression              | <input type="checkbox"/> | Low Blood Pressure   | <input type="checkbox"/> | Other _____                  |                          |

Have you had any serious injury? \_\_\_\_\_ If yes, explain \_\_\_\_\_

**ALLERGIES:** (An allergy is a skin rash, hives, joint pain, swollen glands, stuffy nose, and/or fever after exposure to something to which you are allergic.)

Do you have any allergies?  YES  NO **If "YES", check items to which you are allergic.**

Latex  Bee Stings  Foods  Medications (Please List) \_\_\_\_\_

Other \_\_\_\_\_

**MEDICATIONS:** Do you take any medicine, frequently or regularly?  YES  NO **If "YES", check those medications below.**

- |                |                          |                 |                          |                   |                          |                     |                          |               |                          |
|----------------|--------------------------|-----------------|--------------------------|-------------------|--------------------------|---------------------|--------------------------|---------------|--------------------------|
| Allergy Shots  | <input type="checkbox"/> | Aspirin         | <input type="checkbox"/> | Diabetic Pill     | <input type="checkbox"/> | Heart Rhythm Med.   | <input type="checkbox"/> | Pain Pill     | <input type="checkbox"/> |
| Antacid        | <input type="checkbox"/> | Asthma Medicine | <input type="checkbox"/> | Diuretic (Water)  | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | Sleeping Pill | <input type="checkbox"/> |
| Antidepressant | <input type="checkbox"/> | Birth Control   | <input type="checkbox"/> | Epilepsy Medicine | <input type="checkbox"/> | Insulin             | <input type="checkbox"/> | Tranquilizer  | <input type="checkbox"/> |
| Antihistamine  | <input type="checkbox"/> | Blood Thinner   | <input type="checkbox"/> | Headache Medicine | <input type="checkbox"/> | Laxative            | <input type="checkbox"/> | Prednisone    | <input type="checkbox"/> |

Prescription medicine \_\_\_\_\_

Other, not listed \_\_\_\_\_

**DISABILITY:** Any permanent Physical Disability? If YES, what? \_\_\_\_\_

Do you use any device (i.e. wheelchair, crutches, other)? \_\_\_\_\_

**STUDENT SIGNATURE:** \_\_\_\_\_