SCHOOL OF NURSING
IMMUNIZATION RECORD FORM

Name: _____ **Date of Birth:** _____

Address: _____
(Street) (City) (State) (Zip)

Social Security Number: _____ **Phone:** _____

E-mail Address: _____

Area of Study: (Circle one) **RN** **GN** **NP** **IT**

NEW YORK STATE, PUBLIC HEALTH LAW, CHAPTER 2165 requires the following information regarding MMR immunizations and dates. First dose must be on or after first birthday. Doses must be at least 28 days apart.

MMR (Measles, Mumps, Rubella – Combined) Vaccine ___/___/___ (mm/dd/yy) ___/___/___ (mm/dd/yy)

or

Measles (Rubeola) Immunity: Check & complete all that apply:

- ☐ Two doses of live measles vaccine on or after January 1, 1968: ___/___/___ (mm/dd/yy) ___/___/___ (mm/dd/yy)

OR

- ☐ Date of immune measles titer: ___/___/___ (mm/dd/yy)

OR

- ☐ Date of physician diagnosed measles disease: ___/___/___ (mm/dd/yy)

and

Mumps Immunity: Check & complete all that apply:

- ☐ One dose of mumps vaccine on or after January 1, 1969: ___/___/___ (mm/dd/yy) ___/___/___ (mm/dd/yy)

OR

- ☐ Date of immune mumps titer: ___/___/___ (mm/dd/yy)

OR

- ☐ Date of physician diagnosed mumps disease: ___/___/___ (mm/dd/yy)

and

Rubella (German Measles) Immunity: Check & complete all that apply:

- ☐ One dose of rubella vaccine on or after January 1, 1969: ___/___/___ (mm/dd/yy) ___/___/___ (mm/dd/yy)

OR

- ☐ Date of immune rubella titer: ___/___/___ (mm/dd/yy)

Health Care Provider Signature	License Number	Date (mm/dd/yy)
		___/___/___

NEW YORK STATE, PUBLIC HEALTH LAW, CHAPTER 2167 requires that all college and university students provide the following information by **checking only one box and signing.**

☐ had the meningococcal (Menomune ™) vaccine within the past 10 years (revaccinate every 3-5 years if increased risk continues). Date ____/____ (M Y)

OR

☐ had the meningococcal (Menactra ™) vaccine……..Date ____/_____ (M Y)

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 (my child) will **not** obtain immunization against meningococcal meningitis disease.

_____ _____
Signature Date

PLEASE SUBMIT THIS FORM TO: HEALTH SERVICES OFFICE, ANGELA HALL *revised 2/11*