GENESEO
THE STATE UNIVERSITY OF NEW YORK

Department of Student Health and Counseling

IMMUNIZATION RECORD

Name: _____ Date of Birth: ___/___ /_____ G00#: _____

Phone #: _____ Email: _____

All students MUST provide proof of immunity against COVID-19, measles, mumps, and rubella. Individuals born prior to January 1, 1957 are exempt from this immunization requirement, but the rest of the health requirements must be met. You may have your health care provider complete this page OR attach their Immunization official copy. Upload to your Student Health Portal BEFORE arrival under medical clearances, at myhealth.geneseo.edu, and complete the **required** online forms under Medical Clearances.

REQUIRED IMMUNIZATIONS

COVID VACCINE (Completed no later than 14 days before arrival on campus)
I received □ Pfizer □ Moderna □ Other _____

Dose 1 ___/___ /_____ Dose2: ___/___ /____
Month/Day/Year Month/Day/Year

□ Johnson & Johnson Janssen ___/___ /_____
Month/Day/Year

MMR (2 doses)

MMR #1: ___/___ /_____ AND MMR#2: ___/___ /_____
Month/Day/Year Month/Day/Year

OR

□ ✓ Positive MMR Antibody Titers **MUST ATTACH COPY OF LAB REPORT**

MENINGOCOCCAL A/B IMMUNIZATION/WAIVER

♦ Must Either Report Date of Immunization or Sign Declination below. Choose ONE of the following:

1. □ Meningococcal *ACWY* received NO EARLIER than 1/26/2017 Date: ___/___ /____

2. □ 2 Doses Meningococcal *Bexsero* or *Trumenba*

Dose 1 Date: ___/___ /_____ Dose 2 Date: ___/___ /_____

3. □ I have NOT received a Meningococcal ACWY/B vaccine in the past 5 years. I have read, or have had explained to me, or understand the information regarding meningococcal meningitis disease at https://www.health.ny.gov/publications/2168/ I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal Meningitis.

Student Signature or Parent Signature (if under 18)

X_____ Date: _____

RECOMMENDED IMMUNIZATIONS

Hepatitis A #1___/___ /_____ Hepatitis A #2___/___ /_____
Month/Day/Year Month/Day/Year

Hepatitis B #1___/___ /_____ Hepatitis B #2___/___ /_____
Month/Day/Year Month/Day/Year

Hepatitis B #3___/___ /_____
Month/Day/Year

Tetanus/Diphtheria Booster (within last 10 years):
□ Td ___/___ /_____ □ Tdap ___/___ /_____
Month/Day/Year Month/Day/Year

Human Papilloma Virus (HPV) Vaccine:
HPV #1___/___ /_____ HPV #2___/___ /_____
Month/Day/Year Month/Day/Year

HPV #3___/___ /_____
Month/Day/Year

THIS FORM MUST BE SIGNED BELOW BY A HEALTH CARE PROVIDER TO CERTIFY ITS ACCURACY.

Print or Stamp

Physician Name:_____

Address:_____

_____

Phone Number: _____

Fax Number: _____

Health Care Provider Signature/Stamp:

X_____ Date: _____