**IMMUNIZATION RECORD**

<table>
<thead>
<tr>
<th>Name: ______________________________</th>
<th>Date of Birth: _________</th>
<th>Page 1 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>G00#:_____________________________</td>
<td>Phone #: _______________</td>
<td>Email: ________________</td>
</tr>
</tbody>
</table>

All students MUST provide proof of immunity against 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 you may attach an official copy (signed by your medical provider or school nurse) you must also sign onto your Student Health Portal, at myhealth.geneseo.edu, and complete the required online forms under Medical Clearances.

### REQUIRED IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR #1:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>MMR #2:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>Measles Titer*:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Mumps Titer*:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Rubella Titer*:</td>
<td>(mm/dd/yy)</td>
</tr>
</tbody>
</table>

*attach copy of titer reports to this form

### MENINGOCOCCAL A IMMUNIZATION/WAIVER

☐ Must Either Report Date of Immunization or Sign Declination below. **To be COMPLETED and SIGNED by student or parent/guardian for student under the age of 18.**

New York State Public Health Law requires that all college and university students enrolled must have had a meningococcal ACWY immunization within the last 5 years.

☐ I received the meningococcal ACWY vaccine Date: ______________
The above cannot be the meningococcal B vaccine.

☐ I have not received a Meningococcal ACWY vaccine in the last 5 years. I have read, or have had explained to me, or understand the information regarding meningococcal meningitis disease [https://www.health.ny.gov/publications/2168/](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

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A Vaccine #1:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Hepatitis A Vaccine #2:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Hepatitis B #1:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Hepatitis B #2:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Hepatitis B #3:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Tetanus/Diphtheria Booster (within last 10 years):</td>
<td></td>
</tr>
<tr>
<td>☐ Td ______________________</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>☐ Tdap _____________________</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Human Papilloma Virus (HPV) Vaccine:</td>
<td></td>
</tr>
<tr>
<td>HPV #1:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>HPV #2:</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>HPV #3:</td>
<td>(mm/dd/yy)</td>
</tr>
</tbody>
</table>

### MANDATORY TB SCREENING (see page 2-3).

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print or Stamp</td>
<td></td>
</tr>
</tbody>
</table>

**Physician Name: ______________________________**

**Address: ______________________________________**

**Phone Number: __________________**

**Fax Number: __________________**

**Provider Signature**

X ______________________ Date: ______________
Tuberculosis (TB) is still a worldwide health problem. In consideration of public health on campus and in the community, TB Screening is required for ALL incoming students. The student/patient should complete screening online (MYHEALTH.geneseo.edu). The screening questions are listed below for provider evaluation purposes. ANY Yes responses to question 1-9, the patient will require proof of skin or blood test results in the past 12 months.

**Tuberculosis Screening Questions:**

| Yes | No | 1. | 1. Was the patient a) born outside the United States b) received a BCG vaccine or c) have a positive skin test result?  
If YES, draw an Interferon Gamma Release Assay (IGRA/ T-Spot/Quantiferon) blood test and submit the lab report. Do not plant PPD/skin test. |
|-----|----|---|---|
|     |    | 2. | 2. Was the patient born in one of the countries listed below that have a high incidence of active TB disease?  
If yes, CIRCLE the countries on the back page* and list dates. |
|     |    | 3. | 3. Has the patient had frequent or prolonged visits to one or more of the countries listed above with a high prevalence of TB disease?  
If yes, CIRCLE the countries, listed on back page*. |
|     |    | 4. | 4. Has the patient ever had the BCG vaccine? |
|     |    | 5. | 5. Has the patient ever had close contact with persons known or suspected to have active TB disease? |
|     |    | 6. | 6. Has the patient been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? |
|     |    | 7. | 7. Has the patient been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? |
|     |    | 8. | 8. Has the patient ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease (medically underserved, low-income, or abusing drugs or alcohol)? |
|     |    | 9. | 9. Has the patient ever had a positive TB blood/skin test or been told they have/had TB? |
|     |    | 10. | 10. If the patient had ANY positive TB test result, please submit a chest xray report. Tests/lab reports and chest X-rays should be within the past 12 months. |
|     |    | 11. | 11. If ANY positive TB result, was the patient given counseling about taking anti-tuberculosis medication? |
|     |    | 12. | 12. Has the patient taken anti-tuberculosis medication?  
If yes, please provide what medication(s); duration; if they completed the treatment. |
|     |    | 13. | 13. Do they have signs or symptoms of active TB?  
(Unexplained cough greater than 2 weeks duration, fevers, chills, night sweats, weight loss or swollen glands) |
|     |    | 14. | 14. Are they taking immunosuppressant medications such as prednisone? |
|     |    | 15. | 15. Have they received an organ transplant? |
|     |    | 16. | 16. Do they have HIV disease? |
**Tuberculin Skin Test (TST/PPD) Plant**

<table>
<thead>
<tr>
<th>Date and Time Given/Planted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plant Site</td>
</tr>
<tr>
<td>Drug Manufacturer</td>
</tr>
<tr>
<td>Lot# and Expiration Date</td>
</tr>
</tbody>
</table>

**Nurse/Provider Signature**

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**Tuberculin Skin Test Reading**

<table>
<thead>
<tr>
<th>Date and Time Read</th>
</tr>
</thead>
<tbody>
<tr>
<td>millimeters (mm) of Induration</td>
</tr>
</tbody>
</table>

**Results**

- [ ] Negative  
- [ ] Positive

**Interpretation (mark one)**

**Nurse/Provider Signature**

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**HIGH RISK Countries**

- Afghanistan
- Algeria
- Angola
- Anguilla
- Argentina
- Armenia
- Azerbaijan
- Bangladesh
- Belarus
- Belize
- Benin
- Bhutan
- Bolivia (Plurinational State of)
- Bosnia and Herzegovina
- Botswana
- Brazil
- Brunei Darussalam
- Bulgaria
- Burkina Faso
- Burundi
- Cabo Verde
- Cambodia
- Cameroon
- Central African Republic
- Chad
- China
- China, Hong Kong SAR
- China, Macao SAR
- Colombia (Based on 2017 WHO statistics)
- Comoros
- Congo
- Côte d'Ivoire
- Democratic People's Republic of Korea
- Democratic Republic of the Congo
- Djibouti
- Dominican Republic
- Ecuador
- El Salvador
- Equatorial Guinea
- Eritrea
- Ethiopia
- Fiji
- Gabon
- Gambia
- Georgia
- Ghana
- Greenland
- Guam
- Guatemala
- Guinea
- Guinea-Bissau
- Guyana
- Haiti
- Honduras
- India
- Indonesia
- Iraq
- Kazakhstan
- Kenya
- Kiribati
- Kuwait
- Kyrgyzstan
- Lao People's Democratic Republic
- Latvia
- Lesotho
- Liberia
- Libya
- Lithuania
- Madagascar
- Malawi
- Malaysia
- Maldives
- Mali
- Marshall Islands
- Mauritania
- Mauritius
- Mexico
- Micronesia (Federated States of)
- Mongolia
- Montenegro
- Morocco
- Mozambique
- Myanmar
- Namibia
- Nauru
- Nepal
- New Caledonia
- Nicaragua
- Niger
- Nigeria
- Northern Mariana Islands
- Pakistan
- Palau
- Panama
- Papua New Guinea
- Paraguay
- Peru
- Philippines
- Portugal
- Qatar
- Republic of Korea
- Republic of Moldova
- Romania
- Russian Federation
- Rwanda
- Sao Tome and Principe
- Senegal
- Serbia
- Sierra Leone
- Singapore
- Solomon Islands
- Somalia
- South Africa
- South Sudan
- Sri Lanka
- Sudan
- Suriname
- Swaziland
- Syrian Arab Republic
- Tajikistan
- Tanzania (United Republic of)
- Thailand
- Timor-Leste
- Togo
- Tunisia
- Turkmenistan
- Tuvalu
- Uganda
- Ukraine
- Uruguay
- Uzbekistan
- Vanuatu
- Venezuela (Bolivarian Republic of)
- Viet Nam
- Yemen
- Zambia
- Zimbabwe