



## IMMUNIZATION RECORD

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 G00#: \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

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	RECOMMENDED IMMUNIZATIONS
MMR #1: _____ (mm/dd/yy) MMR #2: _____ (mm/dd/yy) OR Measles Titer*: _____ (mm/dd/yy) Mumps Titer *: _____ (mm/dd/yy) Rubella Titer*: _____ (mm/dd/yy)	Hepatitis A Vaccine #1: _____ (mm/dd/yy) Hepatitis A Vaccine #2: _____ (mm/dd/yy)  Hepatitis B #1: _____ (mm/dd/yy) Hepatitis B #2: _____ (mm/dd/yy) Hepatitis B #3: _____ (mm/dd/yy)
*attach copy of titer reports to this form	Tetanus/Diphtheria Booster (within last 10 years): <input type="checkbox"/> Td _____ (mm/dd/yy) <input type="checkbox"/> Tdap _____ (mm/dd/yy)
<b>MENINGOCOCCAL A IMMUNIZATION/WAIVER</b>	Human Papilloma Virus (HPV) Vaccine: HPV #1: _____ (mm/dd/yy) HPV #2: _____ (mm/dd/yy) HPV #2: _____ (mm/dd/yy)
♦ <u>Must Either Report Date of Immunization or Sign Declination below.</u> To be COMPLETED and SIGNED by student or parent/guardian for student under the age of 18.	<p style="text-align: center;"><b><i>THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER TO CERTIFY ITS ACCURACY.</i></b></p> <p style="text-align: center;"><b><i>Print or Stamp</i></b></p>
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.	
<input type="checkbox"/> I received the meningococcal ACWY vaccine Date: _____ The above <b>cannot</b> be the meningococcal B vaccine.	Physician Name: _____
<input type="checkbox"/> 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 <a href="https://www.health.ny.gov/publications/2168/">https://www.health.ny.gov/publications/2168/</a>	Address: _____ _____
I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal Meningitis.	Phone Number: _____
<b>Student Signature or Parent Signature (if under 18)</b>	Fax Number: _____
X _____ Date: _____	<b>Provider Signature</b>
X _____ Date: _____	X _____ Date: _____