GENESEO
THE STATE UNIVERSITY OF NEW YORK

Department of Student Health and Counseling

IMMUNIZATION RECORD

Immunization Record: (Medical provider's signature/stamp or copy of the record is required)
Student's Name_____ Date of Birth _____/_____/_____ G#_____

MANDATED IMMUNIZATIONS AND SCREENING FOR ATTENDANCE

1. NYS Public Health Law 2165 mandates students born after January 1, 1957, **enrolled in six (6) credit hours or more** provide documented proof of immunity (vaccines or titer (blood) test results against measles, mumps, rubella disease.
MMR #1 (Measles, Mumps, Rubella) Date: ____/____/____
MMR #2 (Measles, Mumps, Rubella) Date: ____/____/____
OR documentation of immunity to measles, mumps, and rubella by separate vaccines or (blood) titer tests
Measles 1 (Rubeola) Date: ____/____/____ **or** Positive/Immune Measles Titer Date: ____/____/____
Measles 2 (Rubeola) Date: ____/____/____
Mumps Date: ____/____/____ **or** Positive/Immune Mumps Titer Date: ____/____/____
Rubella (German measles) Date: ____/____/____ **or** Positive/Immune Rubella Titer Date: ____/____/____
Varicella #1 Date: ____/____/____ **or** Varicella disease Date: ____/____/____
Varicella #2 Date: ____/____/____ **or** Positive/Immune Varicella Titer Date: ____/____/____

2. NYS Public Health Law 2167 mandates ALL students, **regardless of age**, to provide either proof of meningococcal vaccine or signed declination statement rejecting the meningococcal vaccine.

Meningococcal Vaccine Type: _____ Date: ____/____/____(within 5 years of semester start date)

I elected not to be immunized against meningococcal meningitis disease.
I have read or have had information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I decided NOT to be immunized against the meningococcal meningitis disease.

Student Signature: _____ Date: ____/____/____

RECOMMENDED IMMUNIZATIONS:
Tetanus/Diphtheria/Pertussis Date: ____/____/____ (dated within 10 years)

Hepatitis A #1 Date: ____/____/____Hepatitis A #2 Date: ____/____/____
Hepatitis B #1 Date: ____/____/____Hepatitis B #2 Date: ____/____/____ Hepatitis B #3 Date: ____/____/____
Hepatitis A Positive Titer Date: ____/____/____ Hepatitis B Positive Titer Date: ____/____/____

Polio Booster Date: ____/____/____ Varicella disease Yes ____ No ____ Date: ____/____/____

Varicella vaccine # 1 Date: ____/____/____Varicella vaccine #2 Date: ____/____/____or Varicella Positive Titer Date: ____/____/____

COVID-19 Vaccine: ☐Moderna ☐Pfizer ☐Johnson & Johnson

COVID Vaccine #1 Date: ____/____/____ COVID Vaccine #2 Date: ____/____/____ COVID Vaccine Booster Date: ____/____/____

Medical provider signature/stamp or a copy of the medical provider's document must be attached.

_____
MD, NP, or PA's Signature:

_____
MD, NP, or PA's Printed Name:

_____
Address, City, State:

Stamp

Achieved Accreditation by AAAHC

Health Services
Phone: 585.245.5736
Fax: 585.245.5744

Counseling Services
Phone: 585.245.5716
Fax: 585.245.5071

Addiction Counseling & Prevention
Phone: 585.245.5716
Fax: 585.245.5071

Health Promotion
Phone: 585.245.5747
Fax: 585.245.5744