



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

