

STUDENT IMMUNIZATION RECORD: MUST BE SUBMITTED PRIOR TO CLASS REGISTRATION

NAME: _____ DOB: _____

This form must be completed in its entirety, complying with the guidelines specified for each disease.
Please ensure that your physician completes the form as written.

ALL INFORMATION MUST BE IN ENGLISH.

*This requirement is in compliance with NYS Public Health Law, Section 2165 MONTH/ DAY/ YEAR

- A. *MMR (Measles, Mumps, Rubella) if given instead of individual immunizations (**required**)
- Dose 1 – Immunized at 12 months after birth or later..... / /
 - Dose 2 – Immunized at least 30 days after 1st dose..... / /

- B. *Measles (Rubeola) Check appropriate boxes (**required**)
- Born before 1957 and therefore considered immune..... YES NO
 - Had the disease. Confirmed by physician record..... / /
 - Has report of titer. Immune _____ Non-immune _____ Specify date of titer / /
 - Dose 1 – Immunized after 1/1/1968 with live measles vaccine at 12 mo. after birth or later..... / /
 - Dose 2 – Immunized after 1/1/1968 with live measles vaccine at least 30 days after 1st dose..... / /

- C. . Tetanus – Diphtheria immunizations (**required**)
- Completed primary set of tetanus-diphtheria-pertussis..... / /
 - Received combined tetanus/diphtheria/ acellular pertussis (Tdap) booster within the last 10 years..... / /

TO BE COMPLETED AND SIGNED BY STUDENT (OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18)

* This requirement is in compliance with NYS Public Health Law Section 2167

D. *MENINGOCOCCAL (One dose within 5 years) (required)

CHECK ONE (1) BOX ONLY

Meningococcal vaccine Name and date of vaccine: _____ / /

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided (my child) will **not** obtain immunization against meningococcal meningitis disease.

Signed _____ Date _____
Student/Parent (if student is under 18)

STRONGLY RECOMMENDED ADDITIONAL IMMUNIZATIONS

E. Hepatitis B vaccine : Give dates: #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

F. Varicella --- #1 ____/____/____ #2 ____/____/____ or History of Disease YES NO

HEALTH CARE PROVIDER SIGNATURE REQUIRED:

Health Care Provider's Signature _____ DATE _____

PRINT NAME _____

ADDRESS _____

PHONE# _____ FAX# _____