

NAME: _____ DOB: _____

STUDENT IMMUNIZATION RECORD
PROOF OF IMMUNITY IS REQUIRED PRIOR TO REGISTRATION

This form must be completed in its entirety, complying with the guidelines specified for each disease. Failure to comply with these requirements will cause the form to be returned to you for completion. Please ensure that your physician completes the form as written. *These requirements are in compliance with NYS Health Department Immunization Law #2165. ALL INFORMATION MUST BE IN ENGLISH.

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

OR

 - C) Measles (Rubeola) **(required)**
 - i Born before 1957 and therefore considered immune YES NO
 - ii Had the disease. Confirmed by physician record / /
 - iii Has report of titer.....Immune_____ Non-immune_____ Specify date of titer..... / /
 - iv Dose 1-Immunized after 1/1/1968 with live measles vaccine at 12 mo. After birth or later / /
 - v Dose 2-Immunized after 1/1/1968 with live measles vaccine at least 30 days after 1st dose..... / /
 - D) Rubella **(required)**
 - i Born before 1957 and therefore considered immune YES NO
 - ii Had the disease. Confirmed by physician record / /
 - iii Has report of titer.....Immune_____ Non-immune_____ Specify date of titer..... / /
 - iv Immunized with Rubella vaccine at 12 months after birth or later / /
 - E) Mumps **(required)**
 - i Born before 1957 and therefore considered immune YES NO
 - ii Had the disease. Confirmed by physician record / /
 - iii Has report of titer.....Immune_____ Non-immune_____ Specify date of titer..... / /
 - iv Immunized with Mumps vaccine at 12 months after birth or later / /
2. Meningococcal **(required)** Menomune (Quadrivalent Polysaccharide vaccine)..... / / /
or Menactra (conjugate) vaccine..... / / /
3. Tetanus –Diphtheria immunizations **(required)**
 - A) Completed primary set of tetanus-diphtheria-pertussis..... / /
 - B) Received tetanus-diphtheria booster within the last 10 years..... / /
4. Polio **(required)**
 - A) Completed primary series of polio immunizations YES NO / /
 - B) Oral or IPV Date of last booster / /
5. Tuberculosis **(required)**
 - A) PPD (Mantoux) test within past 1 year (tine or monovac not acceptable) Results: _____mm Read: _____ / /
 - B) If positive PPD-chest x-ray required x-ray results: normal abnormal / /

STRONGLY RECOMMENDED ADDITIONAL IMMUNIZATIONS

6. Hepatitis B vaccine: Dates given: dose1 _____/_____/_____ dose 2 _____/_____/_____ dose 3 _____/_____/_____
7. Human Papillomavirus vaccine (Female Students Only): Dates given: dose 1 _____/_____/_____ dose 2 _____/_____/_____
dose 3 _____/_____/_____
8. Varicella
 - A) Had the disease. Confirmed by physician record..... / /
 - B) Has report of titer.....Immune_____ Non-immune_____ Specify date of titer / /
 - C) Immunized with Varicella vaccine dose 1 / /
 - D) Immunized with Varicella vaccine dose 2 (given at least one month after first dose if age 13 or older)..... / /

HEALTH CARE PROVIDER SIGNATURE REQUIRED

Signature _____ Date _____ / _____ / _____

Name (please print) _____ Address _____

Phone() _____ Fax() _____

FOR OFFICE USE ONLY

- | | | |
|---|---|--|
| <input type="checkbox"/> Health record Complete | <input type="checkbox"/> Medical History Incomplete | <input type="checkbox"/> Medical Treatment Acknowledgment Incomplete |
| <input type="checkbox"/> Immunizations Incomplete | <input type="checkbox"/> Physical Exam Incomplete | <input type="checkbox"/> Release of Medical Information Incomplete |

Action needed _____ Reviewed by: _____ Date record complete _____

Entered by _____ (RN Signature) Letter Sent Date _____