CUNY SPH GRADUATE SCHOOL OF PUBLIC HEALTH & HEALTH POLICY

STUDENT IMMUNIZATION RECORD FORM

New York State Public Health Law 2165 requires all students entering a post-secondary institution be immunized against measles, mumps, and rubella (MMR).This law applies to students born on or after January 1, 1957. Requirements are as follows:

PART 1: Student Information (to be complete by the student)

(please print)

Name _____ CUNY First ID # _____

Mailing Address _____

Date of Birth _____ Phone # _____ Email Address _____

PART 2: Immunization History (to be complete by health care provider)

MMR (measles, mumps, rubella) - Given as a combined dose instead of individual immunizations.

Dose 1: Immunized after 1 year of age and after 1972 Date: _____/_____/_____

Dose 2: Immunized after 1972 and at 5 years of age or older Date: _____/_____/_____

----------OR----------

Live Vaccines

Measles Dose 1: immunized on or after January 1 1968 or after first birthday Date: _____/_____/_____

Measles Dose 2: immunized at least 28 days after the first dose Date: _____/_____/_____

Rubella immunized with vaccine on or after 1 year of age and after 1968 Date: _____/_____/_____

Mumps immunized with vaccine after 1 year of age and after 1968 Date: _____/_____/_____

----------OR----------

Titer (blood test) showing positive immunity (Dated lab results must be attached.)

Measles: Date: _____/_____/_____ Pos.___Neg.___

Mumps: Date: _____/_____/_____ Pos.___Neg.___

Rubella: Date: _____/_____/_____ Pos.___Neg.___

Medical /Exemption Waiver: A licensed medical provider must certify that you have a health condition, which is a valid contraindication for receiving a specific vaccine. Please provide this statement from your physician on his/her stationary with stamp, signature, and license number. All medical waivers will be periodically reviewed to see if contraindications still exist.

PART 3: To be complete by health care provider

I certify that the above-named student has received the above immunizations, or I have enclosed laboratory results indicating immunity. Official seal/stamp of medical provider, signature and license # required. Physician/Provider Name (Please Print):_____ Physician/Provider License #_____ Physician/Provider Signature:_____	**Physician/ Provider Stamp**

Send to: **CUNY School of Public Health**
Office of Student Alumni Services
55 West 125th Street – Room 721
New York, NY 10027

CUNY SPH GRADUATE SCHOOL OF PUBLIC HEALTH & HEALTH POLICY

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

New York state law prohibits students from enrolling in classes until they have submitted their Meningitis Acknowledgement form. **This may done online or via this form. Instructions for completing this form online via CUNYfirst can be found at the following link:**

http://www.cuny.edu/about/administration/offices/CIS/CUNYfirst/training/students/Submit-Immunization-Meningitis-Acknowledgement-Form.pdf

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Please complete the items below only if you will not be completing this online via CUNYfirst. Mail the completed form to:

CUNY School of Public Health
Office of Student Alumni Services
55 West 125th Street – Room 721
New York, NY 10027

Check one box and sign below.
I have (for students under the age of 18: My child has):

- ☐ had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: _____
  [Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

- ☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. My child (I) will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider.

- ☐ 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 that my child (I) will **not** obtain immunization against meningococcal meningitis disease.

Signed _____ Date _____
(Parent / Guardian if student is a minor)

Print Student's Name _____ Student Date of Birth _____ /_____ / _____

E-mail address _____ CUNY First ID # _____

Mailing Address _____

Student Phone number _____