

PART I: STUDENT INFORMATION

Name _____
Last Name First Name

Address _____
Street City State Zip

Date of Birth _____ ID# _____ E-Mail _____

Campus Old Westbury, N.Y. Manhattan Central Islip, N.Y. Semester Attending _____

PART II: MENINGOCOCCAL MENINGITIS RESPONSE: New York State Public Health Law §2167
TO BE COMPLETED AND SIGNED BY STUDENT (PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18)

Meningitis vaccine Date _____
 [Note: If you (your child) received the meningococcal vaccine Menomune™ (available before Feb. 2005), please note this vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3 to 5 years after receiving Menomune™.]

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

Signed _____ Date _____

PART III: PROOF OF MEASLES, MUMPS AND RUBELLA IMMUNITY: New York State Public Health Law §2165
A HEALTHCARE PROVIDER MUST COMPLETE THIS SECTION

Measles: Two vaccines after 1/68 at least 30 days apart, and after one year of age; or blood titer showing immunity.
Mumps: One mumps vaccine after 1/69; or blood titer showing immunity.
Rubella: One rubella vaccine after 1/69; or blood titer showing immunity.
Those with a birth date prior to 1/1/57 are exempt from this requirement, but must complete Part II of this form. You must also submit a copy of either a birth certificate or a driver's license to document your birthdate.

A. MMR (Measles, Mumps, and Rubella combined vaccine)
 TWO dates of MMR vaccination: _____ and _____

OR If Measles, Mumps, & Rubella are given as individual vaccines:

B. Measles Immunity – Complete ONE of the following:

1. TWO dates of Measles vaccination: _____ and _____

2. Date of Measles titer: _____ Results _____
 (Please provide a copy of the lab report if immunity is by blood titer)

C. Mumps Immunity – Complete ONE of the following:

1. Date of Mumps vaccination: _____

2. Date of Mumps titer: _____ Results _____
 (Please provide a copy of the lab report if immunity is by blood titer)

D. Rubella – Complete ONE of the following:

1. Date of Rubella vaccination: _____

2. Date of Rubella titer: _____ Results _____
 (Please provide a copy of the lab report if immunity is by blood titer)

Physician Information

Name _____ Phone (____) _____ - _____

License Number/State _____ Date ____/____/____ Signature _____