Student Immunization Form

NEW YORK INSTITUTE OF TECHNOLOGY

PART I: STUDENT INFORMATION

Last name		**First name**	
Date of birth	**NYIT ID**	**Semester attending**	
Email		**Campus** ☐ Old Westbury	☐ Manhattan

PART II: MENINGOCOCCAL MENINGITIS RESPONSE: New York State Public Health Law §2167

Dates of Meningitis Vaccine: 1. MM/DD/YYYY 2. MM/DD/YYYY

[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least one dose of Meningococcal ACWY vaccine not more than five years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a health care provider.]

☐ 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 student) will not obtain immunization against meningococcal meningitis disease.

Student Signature *(Parent/Guardian for Student Under the Age of 18)* **Date**

PART III: PROOF OF MEASLES, MUMPS, AND RUBELLA IMMUNITY: New York State Public Health Law §2165

Measles: Two vaccines after January 1968 at least 30 days apart, and after one year of age; or blood titer showing immunity.

Mumps: One mumps vaccine after January 1969; or blood titer showing immunity.

Rubella: One rubella vaccine after January 1969; or blood titer showing immunity.

Those with a birthdate prior to January 1, 1957 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.

****SUBMITTING FALSE MEDICAL DOCUMENTS IS A VIOLATION OF NYIT STUDENT CODE OF CONDUCT.****

A. MMR (Measles, Mumps, and Rubella combined vaccine)

TWO dates of MMR vaccination: 1. MM/DD/YYYY 2. MM/DD/YYYY

OR If Measles, Mumps, and Rubella are given as individual vaccines

B. Measles Immunity – Complete ONE of the following (Please provide a copy of the lab report if immunity is by blood titer.)

1. TWO dates of measles vaccination: 1. MM/DD/YYYY 2. MM/DD/YYYY

2. Date of measles titer: MM/DD/YYYY Results:

C. Mumps Immunity – Complete ONE of the following (Please provide a copy of the lab report if immunity is by blood titer.)

1. Date of mumps vaccination: MM/DD/YYYY

2. Date of mumps titer: MM/DD/YYYY Results:

D. Rubella – Complete ONE of the following (Please provide a copy of the lab report if immunity is by blood titer.)

1. Date of rubella vaccination: MM/DD/YYYY

2. Date of rubella titer: MM/DD/YYYY Results:

HEALTH CARE PROVIDER INFORMATION (Please note: This form will not be accepted if this section is not completed in its entirety.)

Health Care Provider Name		**License #**
Signature	**Date**	**Telephone**

Health Care Provider Stamp/Office Stamp

PLACE STAMP HERE

OFFICE OF WELLNESS SERVICES INFORMATION

Northern Boulevard, P.O. Box 8000
Old Westbury, NY, 11568-8000
Phone: 516.686.7976 **Fax:** 516.686.1410 **Email:** ows@nyit.edu

nyit.edu

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