

PART I: STUDENT INFORMATION

Name _____
Last name First name

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

Meningitis vaccine Date _____
 [Note: If you (your child) received the meningococcal vaccine Menomune™ (available before February 2005), please note this vaccine's protection lasts for approximately three to five years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within three to five 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 _____
 (PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18)

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

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, and 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)

PLEASE NOTE: THIS FORM WILL NOT BE ACCEPTED IF THIS SECTION IS NOT COMPLETED IN ITS ENTIRETY.

Healthcare Provider Name: _____ License #: _____

Signature: _____ Date: _____ Telephone: _____

Healthcare Provider Signature/Office Stamp: _____