NYIT College of Osteopathic Medicine

STUDENT IMMUNIZATION FORM

PART I: STUDENT INFORMATION

Last Name	**First Name**	
Date of Birth	**NYIT ID**	**Class Year**
Email		

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

Date of Meningitis Vaccine:

[Note: If you (your student) 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 student) will not obtain immunization against meningococcal meningitis disease.

Student Signature **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.	2.
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.	2.
2. Date of measles titer:	Results:	
C. Mumps Immunity – Complete ONE of the following		
1. Date of mumps vaccination:		
2. Date of mumps titer:	Results:	
D. Rubella – Complete ONE of the following		
1. Date of rubella vaccination:		
2. Date of rubella titer:	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		

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