STUDENT IMMUNIZATION RECORD FORM

Name (First, Middle, Last): _____ Date of Birth: _____

Semester Entering LIM College: _____ Email Address: _____

PART I: MENINGOCOCCAL MENINGITIS RESPONSE: NEW YORK STATE PUBLIC HEALTH LAW §2167 (CHECK ONE BOX ONLY)

☐ 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: _____

(student or parent/guardian for students under age 18)

PART II: PROOF OF MEASLES, MUMPS, AND RUBELLA IMMUNITY: NEW YORK STATE PUBLIC HEALTH LAW §2165

MEASLES: Two vaccines at least 320 days apart, on or after one year of age; or blood titer showing immunity; or statement from diagnosing physician that student has had the disease.

MUMPS: One mumps vaccine on or after one year of age; or blood titer showing immunity; or statement from diagnosing physician that student has had the disease.

RUBELLA: One rubella vaccine on or after one year of age; or blood titer showing immunity.

[Note: Those with a birth date prior to January 1, 1957 are exempt from this requirement, but must complete Part I of this form. You must also submit a copy of either a birth certificate or a driver's license to document your birth date.]

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: _____ Results: _____

2. DATE OF MUMPS TITER: _____ Results: _____

(Please provide a copy of the lab report if immunity is by blood titer.)

D. RUBELLA IMMUNITY – COMPLETE ONE OF THE FOLLOWING:

1. DATE OF RUBELLA VACCINATION: _____ Results: _____

2. DATE OF RUBELLA TITER: _____ Results: _____

(Please provide a copy of the lab report; physician diagnosis is NOT acceptable.)

PLEASE NOTE: THIS FORM WILL NOT BE ACCEPTED IF THIS SECTION IS NOT COMPLETED

Healthcare Provider Name: _____ License #: _____

Signature/Stamp: _____ Date: _____ Phone: _____

LIM COLLEGE

Please mail or fax this form to:
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