S U N Y College at Old Westbury

State University of New York
Student Health Services
Old Westbury, New York 11568-0210
Tel: (516) 876-3250 Fax: (516) 876-3142

Immunization Form

NEW YORK STATE PUBLIC HEALTH LAW 2165 requires college students to show proof of immunity to **measles, mumps**, and **rubella**. Any person born prior to 1/1/57 is exempt from this requirement. LAW 2167 states that students may be immunized against **meningitis or must sign the statement below***. This documentation must be on file at the Student Health Services.

NAME_____ MAIDEN NAME_____

DATE OF BIRTH___/___/___Student ID or S.S.#_____PHONE ( ) _____

ADDRESS_____TOWN/CITY_____STATE/ZIP_____

REQUIRED IMMUNIZATIONS--ALL DATES MUST INCLUDE MONTH, DAY, AND YEAR

MEASLES (RUBEOLA) IMMUNITY REQUIRED--must have one of the following:

1. TWO DATES OF MEASLES IMMUNIZATIONS (1)_____ (2)_____
   Both must have been given after 1/1/68 and on or after first birthday.
2. DATE OF MEASLES TITER (**ATTACH COPY OF LAB REPORT**) _____

MUMPS IMMUNITY REQUIRED--must have one of the following:

1. DATE OF ONE MUMPS IMMUNIZATION _____
   Must be after 1/1/69 and on or after first birthday.
2. DATE AND RESULTS OF MUMPS TITER (**ATTACH COPY OF LAB REPORT**) _____

RUBELLA (GERMAN MEASLES) IMMUNITY REQUIRED--must have one of the following:

1. DATE OF ONE RUBELLA IMMUNIZATION _____
   Must have been given after 1/1/69 and on/or after first birthday.
2. DATE AND RESULTS OF RUBELLA TITER (**ATTACH COPY OF LAB REPORT**) _____

Or MMR (MEASLES, MUMPS, RUBELLA COMBINATION) #1_____#2_____
(MUST BE AT LEAST 31 DAYS APART)

***STUDENT ONLY**: If student chooses not to be vaccinated, in accordance with New York State law you must sign this statement: I have read (www.oldwestbury.edu and choose Student Health) 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 **will not obtain immunization against meningococcal** meningitis disease.

Student's signature _____ **Parent/Guardian (if under 18)**_____

Recommended:
TUBERCULOSIS SKIN TEST ADMINISTERED_____TYPE_____RESULTS_____
(Any POSITIVE result MUST have report of Chest X-ray attached)
TETANUS or TDAP _____
HEPATITIS A VACCINE #1 _____ #2 _____
HEPATITIS B VACCINE #1 _____ #2 _____ #3 _____
VARICELLA (Chicken Pox) **VACCINE** _____
MENINGITIS VACCINE _____ * (within the last 10 years)
HPV VACCINE #1 _____ #2 _____ #3 _____

_____ _____

SIGNATURE & **STAMP** OF HEALTH CARE PROVIDER REQUIRED DATE
MUST BE VALIDATED BY OFFICIAL STAMP OR ATTACHED TO OFFICIAL LETTERHEAD OF HEALTH CARE PROVIDER