BRING THIS FORM TO YOUR MEDICAL PROVIDER.

PLEASE NOTE YOU MUST SHOW YOU HAVE ONE OF THE FOLLOWING:

1. (2) MMR Vaccines (The first vaccination cannot be more than 4 days before your first birthday.)
2. Evidence of immunity by history of disease for measles or mumps only and proof of immunity by vaccination or blood test to rubella
3. Serological evidence for measles, mumps, and rubella (blood test proving immunity) – copy of lab report required.

If you are an undergraduate student 22 years of age or older, graduate student, or McGhee student, the Meningococcal Vaccine is optional. To opt out, you must complete this form.

FOR MORE DETAILS, PLEASE VISIT:
www.nyu.edu/health/requirements

QUESTIONS OR CONCERNS?
Email health.requirements@nyu.edu or call (212) 443-1199
Name: _____________________________ School: _____________________________

Date of Birth: ______/_____/______ University I.D. Number: ____________

To be in compliance you must have both items in section 1 or one each of the following in sections 2, 3, and 4 and a vaccination against Meningitis (unless eligible to decline), section 5

For more information please visit nyu.edu/health/requirements

<table>
<thead>
<tr>
<th>Section</th>
<th>Immunization Requirements</th>
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</table>
| **1. M.M.R. (Measles, Mumps, Rubella)** | If given instead of individual immunization
| Dose 1 | Immunized on or after first birthday AND on or after January 1, 1972 |
| | ______/_____/______ |
| | MM DD YY |
| Dose 2 | Immunized 15 months after birth or later AND at least 28 days after first dose |
| | ______/_____/______ |
| | MM DD YY |
| **2. MEASLES (RUBEOLA)** |
| Dose 1 | Immunized on or after first birthday AND on or after January 1, 1968 |
| | ______/_____/______ AND |
| | MM DD YY |
| Dose 2 | Immunized 15 months after birth or later AND at least 28 days after first dose |
| | ______/_____/______ |
| | MM DD YY |
| **3. MUMPS** |
| | □ Dose 1 | Immunized on or after first birthday AND on or after January 1, 1968 |
| | | ______/_____/______ AND |
| | | MM DD YY |
| Dose 2 | Immunized at least 28 days after first dose |
| | ______/_____/______ |
| | MM DD YY |
| **4. RUBELLA (German Measles)** |
| | □ Dose 1 | Immunized on or after first birthday AND on or after January 1, 1968 |
| | | ______/_____/______ AND |
| | | MM DD YY |
| Dose 2 | Immunized at least 28 days after first dose |
| | ______/_____/______ |
| | MM DD YY |
| **5. MENINGOCOCCAL VACCINE** | protecting against A, C, W, and Y (on or after 16th birthday)
| Immunization | Date ______/_____/______ |
| | □ Menomune □ Mencevax □ Menactra □ Other _____________________________ |

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## MENINGITIS B VACCINE

- **Bexsero**
  - Dose 1: / /  
  - MM DD YY
  - Dose 2: / /  
  - MM DD YY

- **Trumenba**
  - Dose 1: / /  
  - MM DD YY
  - Dose 2: / /  
  - MM DD YY
  - Dose 3: / /  
  - MM DD YY

## TETANUS-DIPHTHERIA-PERTUSSIS VACCINE

- Tetanus-Diphtheria-acellular Pertussis (Tdap)
  - / /  
  - MM DD YY

- **Tetanus-Diphtheria (Td) booster within the last ten years**
  - / /  
  - MM DD YY

## POLIO VACCINE

- Dose 1: / /  
  - MM DD YY
- Dose 2: / /  
  - MM DD YY
- Dose 3: / /  
  - MM DD YY
- Dose 4: / /  
  - MM DD YY
- Dose 5: / /  
  - MM DD YY

## VARICELLA (CHICKEN POX)

- Immunization
  - Dose 1: / /  
  - MM DD YY
- Dose 2: / /  
  - MM DD YY

- **Physician-diagnosed history of disease**
  - / /  
  - MM DD YY

- Varicella antibody / /  
  - MM DD YY

## HEPATITIS A & B

- Immunization (Hepatitis A)
  - Dose 1: / /  
  - MM DD YY
  - Dose 2: / /  
  - MM DD YY

- Immunization (Hepatitis B)
  - Dose 1: / /  
  - MM DD YY
  - Dose 2: / /  
  - MM DD YY
  - Dose 3: / /  
  - MM DD YY

- **Hepatitis B surface antibody**
  - / /  
  - MM DD YY

## PNEUMOCOCCAL VACCINE

- **PPSV23 one or two doses**
  - Dose 1: / /  
  - MM DD YY
  - Dose 2: / /  
  - MM DD YY

- **PCV13 one dose**
  - Dose 1: / /  
  - MM DD YY

## HUMAN PAPILLOMAVIRUS (HPV) VACCINE

- **HPV-2**
  - Dose 1: / /  
  - MM DD YY
  - Dose 2: / /  
  - MM DD YY
  - Dose 3: / /  
  - MM DD YY

- **HPV-4**
  - Dose 1: / /  
  - MM DD YY
  - Dose 2: / /  
  - MM DD YY
  - Dose 3: / /  
  - MM DD YY

- **HPV-9**
  - Dose 1: / /  
  - MM DD YY
  - Dose 2: / /  
  - MM DD YY
  - Dose 3: / /  
  - MM DD YY

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**PLEASE NOTE:** This form will not be accepted if this section is not completed in its entirety.