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 over 21, 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
# Student Immunization History Form

**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](http://nyu.edu/health/requirements)

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  
   
   _____/______/_____ 
   
   **Dose 2** Immunized 15 months after birth or later AND at least 28 days after first dose  
   
   _____/______/_____ 

2. **MEASLES (RUBEOLA)**
   - Dose 1 Immunized on or after first birthday AND on or after January 1, 1968
   
   _____/______/_____ AND
   
   **Dose 2** Immunized 15 months after birth or later AND at least 28 days after first dose
   
   _____/______/_____ 

3. **MUMPS**
   - **Dose 1** Immunized on or after first birthday AND on or after January 1, 1968
   
   _____/______/_____ AND
   
   **Dose 2** Immunized at least 28 days after first dose
   
   _____/______/_____ 

4. **RUBELLA (German Measles)**
   - **Dose 1** Immunized on or after first birthday AND on or after January 1, 1968
   
   _____/______/_____ AND
   
   **Dose 2** Immunized at least 28 days after first dose
   
   _____/______/_____ 

5. **MENINGOCOCCAL VACCINE** protecting against A, C, W, and Y (at age 16 or older)
   
   **Immunization Date:** _____/______/_______
   
   □ Menomune □ Mencevax □ Menactra □ Other __________________________

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### ACHA and CDC RECOMMENDED VACCINES

#### Meningitis (B Vaccine)
- **Bexsero**: Dose 1/___/___ Dose 2/___/___
- **MMDDYY**
- **Trumenba**: Dose 1/___/___ Dose 2/___/___ Dose 3/___/___
- **MMDDYY**

#### Tetanus-Diphtheria-Pertussis Vaccine
- **Tetanus-Diphtheria-acellular Pertussis (Tdap)**: /___/___
- **MMDDYY**
- AND/OR **Tetanus-Diphtheria (Td)** booster within the last ten years: /___/___
- **MMDDYY**

#### Polio Vaccine
- Dose 1/___/___ Dose 2/___/___ Dose 3/___/___ Dose 4/___/___ Dose 5/___/___
- **MMDDYY**

#### Varicella (Chicken Pox)
- Immunization: Dose 1/___/___
- **MMDDYY**
- Dose 2/___/___
- **MMDDYY**
- Physician-diagnosed history of disease: /___/___
- **MMDDYY**
- Varicella antibody: /___/___
- **Result**
- Reactive □ Non-reactive □

#### Hepatitis A & B
- Immunization (Hepatitis A): Dose 1/___/___
- **MMDDYY**
- Dose 2/___/___
- **MMDDYY**
- Immunization (Hepatitis B): Dose 1/___/___
- **MMDDYY**
- Dose 2/___/___
- **MMDDYY**
- Dose 3/___/___
- **MMDDYY**
- Hepatitis B surface antibody: /___/___
- **MMDDYY**
- Result
- Reactive □ Non-reactive □

#### Human Papillomavirus (HPV) Vaccine
- **HPV-2**: Dose 1/___/___ Dose 2/___/___ Dose 3/___/___
- **MMDDYY**
- **HPV-4**: Dose 1/___/___ Dose 2/___/___ Dose 3/___/___
- **MMDDYY**
- **HPV-9**: Dose 1/___/___ Dose 2/___/___ Dose 3/___/___
- **MMDDYY**

#### Pneumococcal Vaccine
- **PPSV23**: one or two doses Dose 1/___/___ Dose 2/___/___
- **MMDDYY**
- **PCV13**: one dose Dose 1/___/___
- **MMDDYY**

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

Healthcare Provider Name (MD, DO, NP, RN):

Signature: ____________________________ Date: __________________

Healthcare Provider Stamp or Office Stamp for Address: ____________________________

Telephone: ____________________________ Lic #: __________________

NOTE: PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS