STUDENT IMMUNIZATION HISTORY FORM

Name: __________________________________________________ School: ___________________________

Date of Birth: _________/_________/_________ University I.D. Number: ________________

MM DD YY

Check appropriate items and enter dates as Month/Day/Year.
For more information please visit nyu.edu/health/requirements

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

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

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

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

MENINGOCOCCAL VACCINE (age 16 or after)

Immunization

Date _____/_____/_____

☐ Menomune ☐ Mencevax ☐ Menactra ☐ Other __________________________
## TETANUS-DIPHTHERIA-PERTUSSIS VACCINE

Tetanus-Diphtheria-acellular Pertussis (Tdap)

AND/OR

Tetanus-Diphtheria (Td) booster within the last ten years

## POLIO VACCINE

<table>
<thead>
<tr>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
<th>Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>MM DD YY</td>
<td>MM DD YY</td>
<td>MM DD YY</td>
<td>MM DD YY</td>
</tr>
</tbody>
</table>

## VARICELLA (CHICKEN POX)

Immunization

<table>
<thead>
<tr>
<th>Dose 1</th>
<th>Dose 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>MM DD YY</td>
</tr>
</tbody>
</table>

Physician-diagnosed history of disease

Varicella antibody

Result

Reactive [ ] Non-reactive [ ]

## HEPATITIS A & B

Immunization (Hepatitis B)

<table>
<thead>
<tr>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>MM DD YY</td>
<td>MM DD YY</td>
</tr>
</tbody>
</table>

Hepatitis B surface antibody

<table>
<thead>
<tr>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive [ ] Non-reactive [ ]</td>
</tr>
</tbody>
</table>

Immunization (Combined Hepatitis A and B Vaccine)

<table>
<thead>
<tr>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
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</tr>
</tbody>
</table>

## PNEUMOCOCCAL VACCINE

PPSV23 one or two doses

<table>
<thead>
<tr>
<th>Dose 1</th>
<th>Dose 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>MM DD YY</td>
</tr>
</tbody>
</table>

PCV13 one dose

<table>
<thead>
<tr>
<th>Dose 1</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

## HUMAN PAPILLOMAVIRUS (HPV) VACCINE

[ ] HPV-2 [ ] HPV-4 [ ] HPV-9

<table>
<thead>
<tr>
<th>Dose 1</th>
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<th>Dose 3</th>
</tr>
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<tbody>
<tr>
<td>MM DD YY</td>
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</tr>
</tbody>
</table>

## 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.