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
STUDENT IMMUNIZATION HISTOR Y FORM

Name: __________________________ School: __________________________

Date of Birth: _______ / _______ / _______ University I.D. Number: ______________

MM MM DD DD YY YY

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

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 MM DD DD YY YY

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

_____ / _____ / _____

MM MM DD DD YY YY

2. MEASLES (RUBEOLA)

Dose 1 Immunized on or after first birthday AND on or after January 1, 1968

_____ / _____ / _____ AND

MM MM DD DD YY YY

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

_____ / _____ / _____

MM MM DD DD YY YY

□ Physician-diagnosed history of disease

_____ / _____ / _____

MM MM DD DD YY YY

□ Has report of positive (reactive) immune titer

MUST SUBMIT COPY OF LAB REPORT

_____ / _____ / _____

MM MM DD DD YY YY

3. MUMPS

□ Dose 1 Immunized on or after first birthday

AND on or after January 1, 1968

_____ / _____ / _____ AND

MM MM DD DD YY YY

Dose 2 Immunized at least 28 days after first dose

_____ / _____ / _____

MM MM DD DD YY YY

□ Physician-diagnosed history of disease

_____ / _____ / _____

MM MM DD DD YY YY

□ Has report of positive (reactive) immune titer

MUST SUBMIT COPY OF LAB REPORT

_____ / _____ / _____

MM MM DD DD YY YY

4. RUBELLA (German Measles)

□ Dose 1 Immunized on or after first birthday

AND on or after January 1, 1968

_____ / _____ / _____ AND

MM MM DD DD YY YY

Dose 2 Immunized at least 28 days after first dose

_____ / _____ / _____

MM MM DD DD YY YY

□ Has report of positive (reactive) immune titer

MUST SUBMIT COPY OF LAB REPORT

_____ / _____ / _____

MM MM DD DD YY YY

5. MENINGOCOCCAL VACCINE (on or after your 16th birthday)

Immunization

Date _____ / _____ / _____

□ Menomune □ Mencevax □ Menactra □ Other ________________________________
### ACHA and CDC RECOMMENDED VACCINES

**MENINGITIS B VACCINE**

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

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

- Physician-diagnosed history of disease:
  - __/__/__
    - MM DD YY

  - Varicella antibody: __/__/__
    - Result: MM DD YY
    - Reactive: □ Non-reactive: □

**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: __/__/__
  - Result: MM DD YY
  - Reactive: □ Non-reactive: □

**PNEUMOCOCCAL VACCINE**

- PPSV23 one or two doses
  - Dose 1: __/__/__  Dose 2: __/__/__
    - Doses: MM DD YY  MM DD YY
- PCV13 one dose
  - Dose 1: __/__/__
    - MM DD YY

**HUMAN PAPILLOMAVIRUS (HPV) VACCINE**

- □ HPV-2  □ HPV-4  □ HPV-9

<table>
<thead>
<tr>
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</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.