



New York University Student Health Center

Student Immunization History

PART I To Be Completed by Student			BIRTH DATE			NYU 9 Digit Student ID Number												
LAST NAME			FIRST NAME			MI	MONTH	DAY	YEAR	N			+			+		

PART II Immunization Requirements																	
<p>▶ Measles/Mumps/Rubella: <u>two doses of live MMR administered on or after the first birthday and at least 28 days apart:</u></p>																	
DOSE #1					DOSE #2					<p>▶ Measles:</p> <p>▶ OR <input type="checkbox"/> physician-diagnosed history of disease. <i>Complete date field to the right.</i></p> <p>▶ OR protective-antibody titer:</p> <p>Lab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <i>If positive, then complete date field.</i></p>							
<input type="checkbox"/> Jan	DAY	YEAR	<input type="checkbox"/> Jan	DAY	YEAR	<input type="checkbox"/> Jan	DAY	YEAR	<input type="checkbox"/> Jan	DAY	YEAR	<input type="checkbox"/> Jan	DAY	YEAR	<input type="checkbox"/> Jan	DAY	YEAR
<input type="checkbox"/> Feb			<input type="checkbox"/> Feb			<input type="checkbox"/> Feb			<input type="checkbox"/> Feb			<input type="checkbox"/> Feb			<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0
<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1
<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2
<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3
<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4
<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5
<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6
<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7
<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8
<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9

<p>▶ Rubella:</p> <p>▶ protective-antibody titer:</p> <p>Lab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <i>If positive, then complete date field.</i></p>					<p>▶ Mumps:</p> <p>▶ OR <input type="checkbox"/> physician-diagnosed history of disease: <i>Complete date field to the right.</i></p> <p>▶ OR protective-antibody titer:</p> <p>Lab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <i>If positive, then complete date field.</i></p>						
<input type="checkbox"/> Jan	DAY	YEAR	<input type="checkbox"/> Jan	DAY	YEAR	<input type="checkbox"/> Jan	DAY	YEAR	<input type="checkbox"/> Jan	DAY	YEAR
<input type="checkbox"/> Feb			<input type="checkbox"/> Feb			<input type="checkbox"/> Feb			<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0
<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1
<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2
<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3
<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4
<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5
<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6
<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7
<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8
<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9

Meningococcal Information - FRESHMEN ARE REQUIRED TO SUBMIT PROOF OF VACCINE - ALL OTHERS SEE BELOW

New York State Health Law 2167 requires that all college and university students enrolled for at least (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete this section.

I have had the Meningococcal Meningitis immunization within the past 10 years - Indicate date to the right

Please Note: The vaccine's protection lasts for approximately 3 to 5 years. Re-vaccination may be considered in 3-5 years.

I have read or have had explained to me the information regarding meningococcal meningitis disease and will not obtain immunization - I choose to decline meningococcal vaccine - Indicate decline date to the right and sign below

DATE OF VACCINE	DECLINE DATE				
MONTH	DAY	YEAR	MONTH	DAY	YEAR
<input type="checkbox"/> Jan			<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb			<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0
<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1
<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2
<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3
<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4
<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5
<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6
<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7
<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8
<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9

Student signature or signature of Parent/Legal Guardian for minors

PART III ACHA and CDC Recommendations:

A. CHICKEN POX (varicella) — Two doses given at least four weeks apart or positive titer or disease history required.

DOSE #1	DOSE #2	OR	DATE	OR	DATE								
DATE	DATE		DATE		DATE								
MONTH	DAY	YEAR	MONTH	DAY	YEAR		MONTH	DAY	YEAR		MONTH	DAY	YEAR
<input type="checkbox"/> Jan			<input type="checkbox"/> Jan						<input type="checkbox"/> Jan				
<input type="checkbox"/> Feb			<input type="checkbox"/> Feb						<input type="checkbox"/> Feb				
<input type="checkbox"/> Mar	0	0	<input type="checkbox"/> Mar	0	0				<input type="checkbox"/> Mar	0	0		
<input type="checkbox"/> Apr	1	1	<input type="checkbox"/> Apr	1	1				<input type="checkbox"/> Apr	1	1		
<input type="checkbox"/> May	2	2	<input type="checkbox"/> May	2	2				<input type="checkbox"/> May	2	2		
<input type="checkbox"/> June	3	3	<input type="checkbox"/> June	3	3				<input type="checkbox"/> June	3	3		
<input type="checkbox"/> July	4	4	<input type="checkbox"/> July	4	4				<input type="checkbox"/> July	4	4		
<input type="checkbox"/> Aug	5	5	<input type="checkbox"/> Aug	5	5				<input type="checkbox"/> Aug	5	5		
<input type="checkbox"/> Sept	6	6	<input type="checkbox"/> Sept	6	6				<input type="checkbox"/> Sept	6	6		
<input type="checkbox"/> Oct	7	7	<input type="checkbox"/> Oct	7	7				<input type="checkbox"/> Oct	7	7		
<input type="checkbox"/> Nov	8	8	<input type="checkbox"/> Nov	8	8				<input type="checkbox"/> Nov	8	8		
<input type="checkbox"/> Dec	9	9	<input type="checkbox"/> Dec	9	9				<input type="checkbox"/> Dec	9	9		

B. TETANUS

Diphtheria Pertussis *OR* TDAP

1. Tetanus Booster given within past 10 years

DATE		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

C. POLIO

DATE OF SERIES COMPLETION		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

D. HPV VACCINE

DATE OF SERIES COMPLETION		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

E. HEPATITIS A VACCINE

DOSE #1 DATE		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

DOSE #2 DATE		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

F. HEPATITIS B — Doses #1 and #2 given at least four weeks apart or positive (reactive) surface antibody required.

Three dose series of Hepatitis B vaccine.

DOSE #1 DATE		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

DOSE #2 DATE		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

Positive (reactive) antibody

DOSE #3 DATE		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

DATE		
	DAY	YEAR
<input type="checkbox"/> Jan		
<input type="checkbox"/> Feb		
<input type="checkbox"/> Mar	0 0	0 0 0
<input type="checkbox"/> Apr	1 1	1 1 1 1
<input type="checkbox"/> May	2 2	2 2 2 2
<input type="checkbox"/> June	3 3	3 3 3
<input type="checkbox"/> July	4	4 4 4
<input type="checkbox"/> Aug	5	5 5 5
<input type="checkbox"/> Sept	6	6 6 6
<input type="checkbox"/> Oct	7	7 7 7
<input type="checkbox"/> Nov	8	8 8 8
<input type="checkbox"/> Dec	9	9 9 9

OR

PART IV Health Care Provider Signature and Stamp

PLEASE NOTE: To be completed by Health Care Provider in ink — *Completion Mandatory* — I certify that the immunization information is accurate.

Health Care Provider Name _____
(Please Print)

Signature _____ Date _____

Health Care Provider Stamp or Office Stamp for Address _____

() _____
Telephone Lic. #

COMPLETED BOX

Please fill in oval after signing.

Staff Use Only

No Sign
 No ID

WHERE TO SEND HEALTH HISTORY FORM:

The Student Health History Form must be completed, signed by a health care provider and submitted in the enclosed envelope to:

**New York University Student Health Center
Immunization Record Services
726 Broadway, Suite 357
New York, NY 10003**