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

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

___/___/___

1. 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

___/___/___

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

___/___/___

2. Has physician-diagnosed history of disease

___/___/___

2. 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

___/___/___

Dose 2 Immunized at least 28 days after first dose

___/___/___

3. 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

___/___/___

Dose 2 Immunized at least 28 days after first dose

___/___/___

4. 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 ______/_____/____
- OR
- □ Trumenba
  - Dose 1 ______/_____/____
  - Dose 2 ______/_____/____
  - Dose 3 ______/_____/____

#### TETANUS-DIPHTHERIA-PERTUSSIS VACCINE
- Tetanus-Diphtheria-acellular Pertussis (Tdap)
  - ______/_____/____
- AND/OR
- Tetanus-Diphtheria (Td) booster within the last ten years
  - ______/_____/____

#### POLIO VACCINE
- Dose 1 ______/_____/____
- Dose 2 ______/_____/____
- Dose 3 ______/_____/____
- Dose 4 ______/_____/____
- Dose 5 ______/_____/____

#### VARICELLA (CHICKEN POX)
- Immunization
  - Dose 1 ______/_____/____
  - Dose 2 ______/_____/____
- Physician-diagnosed history of disease
  - ______/_____/____
- Varicella antibody ______/_____/____
- Result
  - Reactive □ Non-reactive □

#### HEPATITIS A & B
- Immunization (Hepatitis A)
  - Dose 1 ______/_____/____
  - Dose 2 ______/_____/____
- Immunization (Hepatitis B)
  - Dose 1 ______/_____/____
  - Dose 2 ______/_____/____
  - Dose 3 ______/_____/____
- Hepatitis B surface antibody
  - ______/_____/____
- Result
  - Reactive □ Non-reactive □

- Immunization (Combined Hepatitis A and B Vaccine)
  - Dose 1 ______/_____/____
  - Dose 2 ______/_____/____
  - Dose 3 ______/_____/____

#### PNEUMOCOCCAL VACCINE
- PPSV23 one or two doses
  - Dose 1 ______/_____/____
  - Dose 2 ______/_____/____
- PCV13 one dose
  - Dose 1 ______/_____/____

#### HUMAN PAPILLOMAVIRUS (HPV) VACCINE
- □ HPV-2
- □ HPV-4
- □ HPV-9
- Dose 1 ______/_____/____
- Dose 2 ______/_____/____
- Dose 3 ______/_____/____

**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