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

<table>
<thead>
<tr>
<th>Section</th>
<th>Immunization Requirements</th>
<th>Immunization Details</th>
</tr>
</thead>
</table>
| **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
\[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]
Dose 2 Immunized 15 months after birth or later AND at least 28 days after first dose
\[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]

| **2. MEASLES (RUBEOLA)** | | \[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{AND}
\end{array}
\]
Dose 1 Immunized on or after first birthday AND on or after January 1, 1968
\[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]
Dose 2 Immunized 15 months after birth or later AND at least 28 days after first dose
\[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]

| **3. MUMPS** | | \[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{AND}
\end{array}
\]
Dose 1 Immunized on or after first birthday AND on or after January 1, 1968
\[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]
Dose 2 Immunized at least 28 days after first dose
\[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]

| **4. RUBELLA (German Measles)** | | \[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{AND}
\end{array}
\]
Dose 1 Immunized on or after first birthday AND on or after January 1, 1968
\[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]
Dose 2 Immunized at least 28 days after first dose
\[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]

<table>
<thead>
<tr>
<th><strong>5. MENINGOCOCCAL VACCINE</strong> protecting against A, C, W, and Y (on or after 16th birthday)</th>
<th>Immunization Date</th>
<th>Immunization Details</th>
</tr>
</thead>
</table>
| Immunization Date | \[
\begin{array}{c}
\text{\_\_\_/\_\_\_/\_\_} \\
\text{MM DD YY}
\end{array}
\]
| Menomune | Mencevax | Menactra | Other |
### MENINGITIS B VACCINE
- Bexsero: Dose 1 __/__/__ Dose 2 __/__/__
- Trumenba: Dose 1 __/__/__ Dose 2 __/__/__

### 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 __/__/__
- Immunization: Dose 2 __/__/__
- Physician-diagnosed history of disease __/__/__
- Varicella antibody __/__/__
- Result
  - Reactive □
  - Non-reactive □

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

### 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