NYU Student Health Center

STUDENT IMMUNIZATION HISTORY FORM

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 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

NYU Student Health Center

STUDENT IMMUNIZATION HISTORY FORM

Name:_____ School: _____

Date of Birth: _____/_____/_____ University I.D. Number: N_____
MM DD 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 DD YY

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

_____/_____/_____
MM DD YY

2. 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

☐ Physician-diagnosed history of disease

_____/_____/_____
MM DD YY

☐ Has report of positive (reactive) immune titer
MUST SUBMIT COPY OF LAB REPORT

_____/_____/_____
MM DD YY

3. 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

☐ Physician-diagnosed history of disease

_____/_____/_____
MM DD YY

☐ Has report of positive (reactive) immune titer
MUST SUBMIT COPY OF LAB REPORT

_____/_____/_____
MM DD YY

4. 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

☐ Has report of positive (reactive) immune titer
MUST SUBMIT COPY OF LAB REPORT

_____/_____/_____
MM DD YY

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

Immunization

Date_____/_____/_____
MM DD YY

☐ Menveo ☐ Mencevax ☐ Menactra ☐ Other _____

ACHA and CDC RECOMMENDED VACCINES

MENINGITIS B VACCINE

☐ Bexsero Dose 1_____/_____/_____ Dose 2_____/_____/_____
MM DD YY MM DD YY

OR

☐ Trumenba Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____
MM DD YY MM DD YY MM DD YY

TETANUS-DIPHTHERIA-PERTUSSIS VACCINE

Tetanus-Diphtheria-acellular Pertussis (Tdap) _____/_____/_____
MM DD YY

AND/OR

Tetanus-Diphtheria (Td) booster within the last ten years _____/_____/_____
MM DD YY

POLIO VACCINE

Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY

VARICELLA (CHICKEN POX)

Immunization

Dose 1_____/_____/_____
MM DD YY

Dose 2_____/_____/_____
MM DD YY

Physician-diagnosed history of disease

_____/_____/_____
MM DD YY

Varicella antibody_____/_____/_____
MM DD YY

Result

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

_____/_____/_____
MM DD YY

Result

Reactive ☐ Non-reactive ☐

Immunization (Combined Hepatitis A and B Vaccine)

Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____
MM DD YY MM DD YY MM DD YY

PNEUMOCOCCAL VACCINE

PPSV23 one or two doses Dose 1_____/_____/_____ Dose 2_____/_____/_____
MM DD YY MM DD YY

PCV13 one dose Dose 1_____/_____/_____
MM DD YY

HUMAN PAPILLOMAVIRUS (HPV) VACCINE

☐ HPV-2 ☐ HPV-4 ☐ HPV-9

Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____
MM DD YY MM DD YY MM DD YY

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