

STUDENT IMMUNIZATION FORM

Name: _____
Home Address: _____

Date of Birth: _____
Phone Number: _____

PART I REQUIRED

New York State Public Health Law 2165 requires post-secondary students to show immunity to Measles, Mumps and Rubella before registering for classes. Persons born prior to January 1, 1957 or taking less than six credits in a semester are exempt from this requirement. Certain medical and religious factors may also qualify for the exemption.

A. MMR (MEASLES, MUMPS, RUBELLA)

First dose of vaccine(s) must be given on or after your 1st birthday, and dose #2 given at least 28 days after dose #1.

TWO DOSES of MMR vaccine:

MMR #1 ___/___/___ MMR #2 ___/___/___

-OR-

TWO DOSES of MEASLES vaccine:

#1 ___/___/___ #2 ___/___/___

AND

ONE DOSE of Mumps vaccine: ___/___/___

ONE DOSE of Rubella vaccine: ___/___/___

-OR-

Antibody Titers (Attach Lab report results)

Date of Measles Immune titer ___/___/___

Date of Mumps Immune titer ___/___/___

Date of Rubella Immune titer ___/___/___

B. MENINGITIS VACCINE (indicate which given):

Required if living in campus housing

MCV4 (Menactra) ___/___/___

MPSV4 (Memomune) ___/___/___

RECOMMENDED

C. TETANUS-DIPHTHERIA-PERTUSSIS: Most recent vaccine/booster (Required within past 10 years):

TD ___/___/___ TDaP ___/___/___

D. Mantoux PPD

Date placed ___/___/___ Date read ___/___/___

Results: Neg Pos. _____ MM _____ Initials

E. HEPATITIS B:

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___

F. HPV (Humanpapilloma Virus vaccine):

Gardasil:

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___

G. VARICELLA (Chickenpox) VACCINE:

#1 ___/___/___ #2 ___/___/___

Meningococcal Meningitis

For all students regardless of age, NYS Public Health Law 2167 mandates that you read and sign Part II.

Meningitis disease is a severe bacterial infection of the bloodstream or meninges (a thin layer covering the brain and spinal cord). It is a relatively rare disease and usually occurs as a single isolated event. Clusters of cases or outbreaks are rare in the United States. It is transmitted through air via droplets of respiratory secretions and direct contact with an infected person. Direct contact, for these purposes, is defined as oral contact with shared items such as cigarettes or drinking glasses or through intimate contact such as kissing. Although anyone can come into contact with the bacteria that causes meningococcal disease, data also indicates certain social behaviors—such as exposure to passive and active smoking, bar patronage and excessive alcohol consumption—may put students at increased risk for the disease. Patients with respiratory infections, compromised immunity, those in close contact to a known case and travelers to endemic areas of the world are also at increased risk.

The early symptoms usually associated with meningococcal disease include fever, severe headache, stiff neck, rash, nausea, vomiting and lethargy, and may resemble the flu. The disease progresses rapidly, often in as little as 12 hours. The disease is occasionally fatal. The symptoms may appear two to 10 days after exposure, but usually within five days. Casual contact as might occur in a regular classroom, office or factory setting is not usually significant enough to cause concern.

Presently there is a vaccine that will protect against some strains of meningococcus. For the most part, the vaccine has been shown to be safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to two days. If you wish to receive the meningococcal vaccine, contact your health care provider.

PART II MENINGOCOCCAL MENINGITIS RESPONSE

Check one (1) box only and sign. If under 18, parent must sign.

I (my child) had the meningococcal meningitis immunization within the past 10 years. ***This vaccine is required for all Sage students living in campus housing.***

Signature _____ Date _____

I am NOT living on campus and I have read the information regarding meningococcal meningitis disease and I understand the risk of not receiving the vaccine. I (my child) will not obtain immunization against meningococcal meningitis disease at this time.

Signature _____ Date _____

Health Care Provider Signature Required OR Attach an Official Copy of Immunization records (signed by Medical Provider or School Nurse)

Name _____
Signature _____

Address _____
Phone () _____ Fax () _____