MEDAILLE COLLEGE IMMUNIZATION RECORD

NAME: _____ _____ _____ DATE OF BIRTH: _____
Last First MI

ADDRESS: _____
Street City State Zip

PHONE #: (_____) _____ STUDENT ID or SSN# _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

REQUIRED: **MMR (Measles, Mumps, Rubella)** *Proof required if born on or after January 1, 1957.*

Vaccination	Vaccine Date (Month/Day/Year)	Or Serology Results/Date
2 MMR's (combo measles, mumps & rubella vaccine) 1st dose after 1st birthday; 2nd dose at least 28 days later. **(OR list individual vaccines below)**	#1 #2	
2 MEASLES 1st dose after 1st birthday; 2nd dose at least 28 days later	#1 #2	_____/_____/_____ mm dd yy **IMMUNE** **NOT IMMUNE** (Please circle result) Attach lab results &/or note if immune
1 MUMPS after 1st birthday		_____/_____/_____ mm dd yy **IMMUNE** **NOT IMMUNE** (Please circle result) Attach lab results &/or note if immune
1 RUBELLA after 1st birthday		_____/_____/_____ mm dd yy **IMMUNE** **NOT IMMUNE** (Please circle result) Attach lab results &/or note if immune

RECOMMENDED: **MENINGOCOCCAL VACCINE** Must be within the past 5 years

***** (Student may decline meningococcal vaccination by completing meningitis response below) *****

Meningococcal Vaccine within the past 5 years _____/_____/_____
mm dd yy

[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.]

_____ _____
Health Care Provider Signature **Address**

_____ (_____) _____
Health Care Provider Name Printed **Telephone Number** **Date**

***** IMPORTANT—THIS MENINGITIS RESPONSE IS REQUIRED FOR ALL STUDENTS NOT VACCINATED IN THE PAST 5 YEARS *****
While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis at: http://www.medaille.edu/mngdisease

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease.

_____ _____
Signature of student if 18 years of age or older or parent/guardian if student is under 18 years of age **Date**

All students must submit this form prior to class attendance. Failure to do so will result in your removal from class in compliance with New York State Public Health Law. Please return this form to: Medaille College Health Center, 18 Agassiz Circle, Buffalo, NY 14214 or FAX to: (716) 880-3399