GCNYC
Glasgow Caledonian
New York College

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 22 years of age or older, the Meningococcal Vaccine is optional.

New York State Public Health Law requires that post-secondary institutions inform all students about Meningococcal disease, make them aware of being vaccinated, and allow those students to choose their actions. The institution must have either a record of immunization or a signed statement from the student indicating that they had been made aware of the vaccine and choose not to, or to notify the school if they plan on acquiring the vaccine within the next 30 days.

Therefore, after reviewing the information below on meningococcal disease you must make a decision regarding the vaccine. Indicate on this form whether you 1) choose not to be vaccinated or 2) plan on being vaccinated in the next 30 days: Meningococcal disease is a potentially fatal bacterial infection commonly referred to as meningitis. Meningococcal disease is rare, however its initial flu-like symptoms make diagnosis difficult. If not treated early, the disease can lead to brain damage, vital organ failure, permanent disability and even death. Cases of meningococcal disease among teens and young adults 15 to 24 years of age have more than doubled since 1991. Recent studies indicate that college students living in dormitories and particularly freshmen dormitory residents are at increased risk of infection. An estimated 100 to 125 cases of meningococcal disease occur on college campuses each year. Of those students infected as many as 15 may die.

The meningococcal vaccine protects against four of the five strains of the bacteria which causes meningococcal disease (strains A, C, Y, and W-135). It is estimated that vaccination would prevent approximately two-thirds of all cases of meningococcal disease in college students and up to 88% of deaths. The vaccine is considered safe and is well tolerated with the most common side effect being soreness at the injection site. It provides protection against meningococcal disease for three to five years. The Haemophilus influenza type b (Hib) vaccine given to infants and young children is often referred to as a "meningitis vaccine". The Hib vaccine does not protect against meningococcal disease and does not meet the vaccination requirement.

Additional information can be obtained on the Centers for Disease Control and Prevention (CDC) website at http://www.cdc.gov/health/diseases.htm (select meningococcal disease) or the American College Health Association website at http://www.acha.org .

To opt out, you must check the "I do not wish to receive the vaccine" box in section 5.

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STUDENT IMMUNIZATION HISTORY FORM

Name:____

Date of Birth: ________/________/________ Student I.D. Number: ____________________________
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

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 ____________________

☐ I do not wish to receive the vaccine

☐ I plan on being vaccinated in the next 30 days

☐ My immunization record is attached

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