CAZENOVIA COLLEGE IMMUNIZATION FORM

To Be Completed by Healthcare Provider

NAME _____ **DATE OF BIRTH** _____ **DATE** _____

HIGH SCHOOL NAME/PHONE NUMBER _____

New York State Public Health Law requires that all students born after December 31, 1956 and taking 6 or more credits per semester demonstrate proof of immunity to measles, mumps, and rubella. Public Health law requires students to sign a response form about the risks associated with meningitis and the benefits of vaccination. Please discuss immunizations with your healthcare provider.

REQUIRED VACCINES

A. M.M.R. (Measles, Mumps, and Rubella) – two doses are required **OR** individual vaccine as noted below

1. Dose 1 given at 12 months after birth or later……1.___/___/___
2. Dose 2 given no sooner than 28 days after Dose 1…….2.___/___/___

B. MEASLES (Rubeola) – two doses required if no MMR's given; check all that apply

1. Immunized with live vaccine at 12 months after birth or later……...1.___/___/___2.___/___/___
2. Has report of positive immune titer. Specify date……...___/___/___
3. Had disease confirmed by doctor's records……..……..___/___/___

C. RUBELLA (German Measles) – clinical history is not acceptable; check all that apply

1. Immunized with live rubella vaccine at 12 months after birth or later…….……..1.___/___/___
2. Has report of positive immune titer. Specify date……..……___/___/___

D. MUMPS – check all that apply

1. Immunized with live vaccine at 12 months after birth or later……1.___/___/___
2. Has report of positive immune titer. Specify date…….___/___/___
3. Had disease confirmed by doctor's records……___/___/___

E. TETANUS – Primary series with DtaP or DTP and booster with Td or Tdap within the last 10 years

1. Primary series completed……1.___/___/___
2. Booster given…….…Tdap (Adacel or Boostrix) ___/___/___.....Td ___/___/___

F. TUBERCULOSIS Screening – Required for high risk populations regardless of prior BCG inoculation

1. PPD (Mantoux) within 12 months……Result_____x_____mm induration…….___/___/___
2. Chest X-RAY ……Result_____....___/___/___
3. QuantiFERON ……Result_____....___/___/___
3. INH Treatment……Yes_____No_____...Duration_____months.....___/___/___
4. Received BCG vaccine…….Yes_____No_____.....___/___/___

G. POLIO

1. Completed primary series of polio immunizations…….___/___/___
2. Received Booster…….___/___/___

H. HEPATITIS B (or Twinrix see letter L below)

1. Dose #1___/___/___.....Dose #2___/___/___.....Dose #3___/___/___ …..Two-Dose Series…Yes_____
2. Hepatitis B surface antibody ___/___/___.....Reactive_____.....Non-Reactive_____

RECOMMENDED VACCINES

I. VARICELLA

1. Had disease_____……Date___/___/___ Titer Result_____.……Date___/___/___
2. Immunized with Varicella vaccine…….....1.___/___/___2.___/___/___

J. MENINGITIS (MPSV4/MCV4)

1. Menomune____/____/___.....Menactra____/___/___ …….Menveo ___/___/___

K. MENINGITIS B: Bexsero 1.___/___/___2.___/___/___ Trumenba 1.___/___/___ 2.___/___/___3.___/___/___

L. HEPATITIS A OR TWINRIX (Check one)

1. Immunized for Hepatitis A ___Twinrix____ (check and enter dates).1.___/___/__2.___/___/__3.___/___/__

M. HPV VACCINE (GARDASIL)…Dose #1___/___/___.....Dose #2___/___/___.....Dose #3___/___/___

N. INFLUENZA VACCINE (If given in current season) ___/___/___

List other relevant vaccines given_____

Signature of Healthcare Provider	**Printed Name or Stamp**	**Phone**	**Date**

Please return to: Cazenovia College Health Services, 10 Seminary Street, Cazenovia, New York 13035 (315-655-7122)