IMMUNIZATION FORM — Health Center (516) 876-3250

Please have your Healthcare Provider complete this proof of immunization form including Provider's signature and stamp on the bottom of this form or attach immunizations on Provider's letterhead. Immunizations may be available from your previous academic institution, either high school or college/university.

Return this form by mail: SUNY Old Westbury, Student Health Center, P.O. Box 210, Old Westbury, NY 11568-0210; by Fax: (516) 876-3142; or by E-mail: studenthealth@oldwestbury.edu

Name: _____ Date of Birth: _____/_____/_____

Student ID No.: _____ Phone No: _____

Address: _____ Town/City: _____

State/Zip: _____ Birth Country: _____

REQUIRED IMMUNIZATIONS – ALL DATES MUST INCLUDE MONTH, DAY, AND YEAR

MEASLES, MUMPS, & RUBELLA (MMR VACCINE):

TWO doses of MMR vaccine after one year of age: MMR # 1: _____/_____/_____ MMR # 2: _____/_____/_____

-OR-

MMR Titer Date: _____/_____/_____

Measles Titer Value*: _____ Mumps Titer Value*: _____ Rubella Titer Value*: _____

*Please attach copy of titer values to this form

MENINGITIS VACCINE RESPONSE:

Meningitis A Vaccine: _____/_____/_____ Meningitis B Vaccine: _____/_____/_____ (within the last 5 years)

-OR-

Meningitis Declination:

If student chooses not to be vaccinated in accordance with New York State law, you must sign this statement: I have read or have had explained to me the information regarding meningococcal meningitis disease (www.health.ny.gov/publications/2168) from my private healthcare provider. I understand the risks of not receiving the vaccine. I have decided that I/my child will NOT obtain immunization against meningococcal meningitis.

Student's Signature: _____ _____/_____/_____

(Parent/Guardian if under 18) Date

RECOMMENDED VACCINES

TB SCREENING

Students from the following areas are required to have tuberculosis screening: Africa, Eastern Europe, Russia, Mexico, Central America, South America, Asia, The Middle East, The Pacific Islands, and the Caribbean. This test must be completed within 12 months prior to starting classes.

☐ I was **not** born in or had an extended stay in any country/region listed above.

Tuberculosis Skin Test (Mantoux): Date Given: ____/____/_____ Date Read: ____/____/_____ Results (mm): _____

If you previously received a **BCG** vaccine, a blood test **(Quantiferon Gold** is the preferred test) to indicate absence of TB.

Date: _____/_____/_____ Result (Check One) ☐ Positive ☐ Negative

If a current or past TB screening or Quantiferon Gold Test was positive, you will need to complete the following:

Chest X-ray Date: _____/_____/_____ Result (Check One) ☐ Positive ☐ Negative

Treatment: ☐ YES ☐ NO - Document drug/dose/frequency _____ Date & Length _____

Document reason prophylaxis or treatment not done _____

Tetanus or DTAP: _____/_____/_____ (within the last 10 years)

Hepatitis A Vaccine: (1) _____/_____/_____ (2) _____/_____/_____

Hepatitis B Vaccine: (1) _____/_____/_____ (2) _____/_____/_____ (3) _____/_____/_____

Varicella Vaccine: (1) _____/_____/_____ (2) _____/_____/_____

HPV Vaccine: (1) _____/_____/_____(2) _____/_____/_____ (3) _____/_____/_____

SIGNATURE & STAMP OF HEALTHCARE PROVIDER REQUIRED DATE