**IMMUNIZATION REQUIREMENTS**

Name: __________________________________________________ Date of Birth: _________________________

**Immunizations** – Student may submit with certified immunization record or healthcare provider can complete and sign.

**REQUIRED FOR ALL STUDENTS**

1. **MEASLES-MUMPS-RUBELLA (MMR) – New York State PHL Section 2165.**

   MMR (Measles, Mumps, Rubella)  
   Date of: Dose #1 __________ Dose #2 ____________

   If born on or after 1/1/57, two doses of the live vaccine required. First vaccine must have been received no sooner than 4 days prior to your first birthday. Second vaccine must be given after 15 months of age and at least 28 days after the first vaccine.

   Measles (2 vaccines)  Dose #1 ______ Dose #2 ______ Disease Date: _______ Serology Date: _______ Immune

   Mumps (1 vaccine)  Dose #1 ______ Disease Date: _______ Serology Date: _______ Immune

   Rubella (1 vaccine)  Dose #1 ______ Disease cannot be diagnosed Serology Date: _______ Immune

2. **MENINGITIS RESPONSE – New York State PHL Section 2167.**

   ALL STUDENTS MUST COMPLETE THIS RESPONSE (INCLUDING THOSE BORN BEFORE 1/1/57)

   Date of Meningococcal Immunization within past 10 years:
   One dose of either ☐ Menomune™ or ☐ Menactra™  
   Month __________ Day __________ Year __________

   I have read or had explained to me the fact sheet enclosed regarding meningococcal disease and am declining the vaccine at this time. I am fully aware of the risks associated with the disease and of the availability and effectiveness of the vaccine.

   ___________________________________________________________ ____________                         ______________ ________
   Signature of student (or parent/guardian if student is under 18)        Date

**ADDITIONAL REQUIRED FOR ALL NURSING STUDENTS**

Varicella Vaccine – Susceptible students 13 years of age, two doses 4-8 weeks apart or date of 1 dose before 13 years of age, disease or serology results.

   Dose #1 ______ Dose #2 ______ Disease Date: _______ Serology Date: _______ Immune

Tetanus, Diphtheria, Pertussis  
   Dose within 10 years. Please specify: ☐ Td or ☐ Tdap  

   Month __________ Day __________ Year __________

Hepatitis B Vaccine: Series of 3 doses:  Dose #1 ______ Dose #2 ______ Dose #3 ______

Flu Shot – submit proof of most recent vaccine if received.  
   Date: __________ Name: ___________

   Lot Number: ___________ Shot or Mist (circle method received by)

**NOT REQUIRED**

Polio Vaccine  
   Date series was completed:  
   Month __________ Day __________ Year __________

Hepatitis A Vaccine: Series of 2 doses:  Dose #1 ______ Dose #2 ______

HPV: Series of 3 doses:  Dose #1 ______ Dose #2 ______ Dose #3 ______

**PHYSICIAN SIGNATURE**  

_________________________________________ DATE

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