

# IMMUNIZATION RECORD

**Immunization records are required prior to registration**  
 Please complete this form and return it to [medicalrecords@baruch.cuny.edu](mailto:medicalrecords@baruch.cuny.edu).

*Document must be legible to be processed. Students are responsible for obtaining an official translation of foreign records prior to submission. \*Students born prior to January 1, 1957 are exempt from the measles, mumps, and rubella requirement. All students registering for 6 credits or more (or its equivalent) must also complete Part 3 - Meningococcal Vaccination Response on reverse side.*

Part 1: Student Information -- To be completed by the student --			
Name (please print) _____			
Last name	First name	Undergrad/Grad	
Date of Birth	EMPL ID #	Daytime phone	Email address
____ / ____ / ____ <i>mm dd yyyy</i>	_____	(    ) _____	_____

### Information to Complete Immunization Requirements

**Measles, Mumps, Rubella:**

New York State Public Health Law 2165 requires all students entering a post-secondary institution to provide their health services center with proof of immunity to measles, mumps and rubella. This law applies to students born on or after January 1, 1957, who are registered for 6 or more credits (or its equivalent) regardless of degree or non-degree status at a CUNY campus.

**ACCEPTABLE PROOF OF IMMUNITY MAY INCLUDE:**

- (1) Immunization cards from childhood (yellow card), signed and stamped.
- (2) Immunization records from college, high school or other schools you attended.
- (3) Signed and stamped immunization record from your health care provider or clinic. Note: Immunization records obtained from a public health department immunization information system. Students born after 1994 who were raised in New York City can check the Citywide Immunization Registry for their records by calling 311.
- (4) Copy of lab report, (also known as titer or serology), showing immunity to measles, mumps and rubella.
- (5) Proof of honorable discharge from the armed services within 10 years from the date of application will enable the student to attend school pending actual receipt of the immunization records from the armed services.

**\*\*If you attended a CUNY college, your immunization record will be available at your new school\*\***

Part 2: Immunization History -- To be completed by a health care provider -- *Documentation must be included*			
<b>Provider: All dates must include month, day, and year. Please mark an (X) in the appropriate boxes</b>			
<b>A.</b>	<b>Measles, mumps and rubella must be live vaccine and given no more than 4 days prior to first birthday.</b> MMR ( <i>measles, mumps, rubella</i> ) – if given as combined dose instead of individual vaccine. <input type="checkbox"/> Dose 1: No more than 4 days prior to first birthday, <b>AND</b> on or after April 23, 1971  <input type="checkbox"/> Dose 2: At least 28 days after 1 <sup>st</sup> vaccine	<b>month</b>	<b>day</b>
		_____	_____
<b>O R</b>	<input type="checkbox"/> <b>Measles (Rubeola) Dose 1:</b> Immunized on or after Jan. 1, 1968 and first birthday <b>AND</b> <input type="checkbox"/> <b>Measles (Rubeola) Dose 2:</b> Immunized at least 28 days after the first dose <input type="checkbox"/> <b>Rubella</b> Immunized after 1969 and on or after first birthday <input type="checkbox"/> <b>Mumps</b> Immunized after 1968 and on or after first birthday	_____	_____
<b>O R</b>	<b>Titer (blood test) showing positive immunity (<i>Dated lab results MUST be attached</i>)</b> <input type="checkbox"/> <b>Measles</b> <input type="checkbox"/> <b>Mumps</b> <input type="checkbox"/> <b>Rubella</b>	_____	_____
<b>B.</b>	<b>Health care provider information: (Please include official stamp)</b> <b>Name:</b> _____ <b>Address:</b> _____  <b>Signature:</b> _____ <b>License #:</b> _____ <b>Phone :(    )</b> _____		

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to the Medical Records Unit.

Name (please print) \_\_\_\_\_  
Last name
First name
Middle Initial

**Part 3: Meningococcal Meningitis** **To be completed by the student**

**Instructions:** *Please check one box in Section A below and sign and date in Section B*

**A.** I have (for students under the age of 18: My child has):

had meningococcal immunization within the past 5 years. The vaccine record is attached.

[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.]

read, or have had explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease within 30 days from my private health care provider.

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

**B.** \_\_\_\_\_

Student/ Parent Signature if student is under 18 years. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
mm dd yyyy

**How do I get more information about meningococcal disease and vaccination?**

- Contact your primary care provider or the Baruch College Student Health Center at 138 East 26<sup>th</sup> Street or visit the NYS Department of Health website at: <http://www.health.ny.gov/publications/2168/>

**Additional information is also available on the following websites:**

- [www.health.state.ny.us](http://www.health.state.ny.us) (New York State Department of Health)
- <http://www.cdc.gov/vaccines/vpd-vac/> (Centers for Disease Control and Prevention)
- [www.acha.org](http://www.acha.org) (American College Health Association)

**TO SUBMIT IMMUNIZATION RECORDS:**

Email: [medicalrecords@baruch.cuny.edu](mailto:medicalrecords@baruch.cuny.edu)

**Part 4: For Office of Health Services Staff Use Only**

Processed by: \_\_\_\_\_ rec: \_\_\_\_\_ ent: \_\_\_\_\_

Staff Name: \_\_\_\_\_ Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_