



Student MMR Immunization Form REQUIRED

RETURN FORM TO:

NYU Student Health Center • Immunization Record Services • 726 Broadway, Suite 336 • New York, NY 10003 • Tel: (212) 443-1199 • Fax: (212) 443-1198

Name: _____ School: _____

Date of Birth: ____/____/____ University I.D. Number: N- _____

* Persons born before January 1, 1957 are exempt from this requirement and do not need to submit this form.

TO BE IN COMPLIANCE, YOU MUST HAVE BOTH ITEMS IN SECTION A...

A. M.M.R. (Measles, Mumps, Rubella) If given instead of individual immunization. Month / Day / Year
 1st Dose: Immunized on or after first birthday, AND on or after January 1, 1972 ____/____/____
 2nd Dose: Immunized 15 months after birth or later, AND at least 28 days after first dose ____/____/____

OR ONE EACH OF THE FOLLOWING: B, C, AND D.
Check appropriate items and enter dates.

B. MEASLES (Rubeola)

1. ____ Had the disease, confirmed by office record ____/____/____
 2. ____ Has report of adequate immune titer - MUST SUBMIT COPY OF LAB REPORT ____/____/____
 3. ____ Dose 1: Immunized on or after first birthday AND on or after January 1, 1968 ____/____/____

AND

Dose 2: Immunized 15 months after birth or later AND at least 28 days after first dose ____/____/____

C. MUMPS

1. ____ Had the disease, confirmed by office record ____/____/____
 2. ____ Has report of adequate immune titer - MUST SUBMIT COPY OF LAB REPORT ____/____/____
 3. ____ Dose 1 Immunized on or after first birthday AND on or after January 1, 1969 ____/____/____

AND

Dose 2: Immunized at least 28 days after first dose ____/____/____

D. RUBELLA (German Measles)

1. ____ Has report of adequate immune titer - MUST SUBMIT COPY OF LAB REPORT ____/____/____
 2. ____ Dose 1 Immunized on or after first birthday AND on or after January 1, 1969 ____/____/____

AND

Dose 2: Immunized at least 28 days after first dose ____/____/____

NOTE: PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

PLEASE NOTE: This form will not be accepted if this section is not completed in its entirety.

Healthcare Provider Name (MD, NP, RN): _____
 Signature: _____ Date: _____
 Healthcare Provider Stamp or Office Stamp for Address: _____
 Telephone: _____ Lic #: _____