Touro College

Office of the Registrar

Student Immunization Record

This form is to be completed by all students born on or after January 1,1957

Part 1- Student Information (to be completed by student)

Name_____
First Last Middle/Maiden

Social Security #_____Touro I.D. #_____ Prog/Ext_____

Date of Birth_____/_____/_____

Mailing Address

Number and Street_____Apt. #_____

City_____ State_____ Zip Code_____

Telephone Number ( )_____ ( )_____
DAY EVENING

Check at least one of the statements below.
(1) Part II below is complete for each disease. I have no acceptable alternate record or exemptions to submit.
(2) Alternate records are attached for each disease for which Part II (below) or Part III (reverse) is not complete.
(3) Part III on reverse is complete for each vaccination for which I clain a medical exemption.

Signature_____ Date_____

PART II- VACCINATION RECORD(To be completed by health care provider)

		Measles	Rubella	Mumps	Or combined MMR
Vaccination Date (Two doses required for Measles or MMR)	Dose 1				
	Dose 2				
Disease History (date of onset)					
Serology Date and Results (indicate + or -)					
Scheduled date for Dose 2					

IMPORTANT NOTE ABOUT RE-VACCINATION: MEASLES-If administered prior to 1968 and not specified as "live" and/or if student was less than 12 months of age for first dose and /or less that 15 months of age for second dose, vaccination must be repeated.Indicate date for follow-up. MUMPS AND RUBELLA-if vaccination was given prior to 1969 and/or if patient waslessthan 12 months of age vaccination must be repeated.

I certify that the above information is correct. (Must be signed by physician, nurse or school official.)

NAME/TITLE_____ CLINIC_____
SIGNATURE_____ ADDRESS_____
DATE_____ PHONE_____

PART III-MEDICAL EXEMPTION FROM IMMUNIZATION(to be completed by health care provider)
I certify that it is medically contraindicated for the above named person to be vaccinated for the disease(s) indicated below because of the stated medican reasons.(Reason and expiration date-or state if permanent-required for each disease.)

CHECK DISEASE(S)- INDICATE MEDICAL REASON(S) FOR CONTRAINDICATION	VALID THROUGH DATE
MEASLES	___/___/____
MUMPS	___/___/____
RUBELLA	___/___/____

Must be signed by physician or nurse practitioner to be acceptable

NAME/TITLE_____ CLINIC_____

SIGNATURE_____ ADDRESS_____

DATE_____ PHONE_____

RETURN BY MAIL OR IN PERSON TO THE OFFICE OF THE REGISTRAT AS INDICATED BELOW:

IF YOU ARE ENROLLED IN:	RETURN THE COMPLETED FORM TO:
NYSCAS- SCHOOL OF GENERAL STUDIES- ALL SITES	**MAIN CAMPUS** **27-33 WEST 23RD STREET** **NEW YORK, NY 10010**
LAS MANHATTAN WOMEN'S PROGRAM	
SCHOOL OF HEALTH SCIENCES-MANHATTAN	
GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY	
MASTERS IN INTERNATIONAL BUSINESS FINANCE	
MASTERS IN JUDAIC STUDIES	
LAS FLATBUSH MEN'S OR WOMEN'S PROGRAM	**TOURO BROOKLYN CENTER** **1602 AVENUE J** **BROOKLYN, NY 11230**
LANDER COLLEGE FOR MEN-KEW GARDEN HILLS	
NYSCAS- AVENUE J	
SCHOOL FOR LIFELONG EDUCATION	
MACHON L'PARNASSAH: INSTITUTE FOR PROFESSIONAL STUDIES	
NYSCAS-BENSONHURST or BOROUGH PARK	1870 STILLWELL AVE. BROOKLYN,NY 11223
NYSCAS- BRIGHTON or STARRETT CITY	532 NEPTUNE AVE. BROOKLYN, NY 11224
NYSCAS-TOURO COMPUTER CENTER	1726 KINGS HIGHWAY BROOKLYN, NY 11229
SCHOOL OF HEALTH SCIENCES- BAYSHORE	1700 UNION BLVD BAY SHORE, NY 11706
JACOB D. FUCHSBERG LAW CENTER	300 NASSAU ROAD HUNTINGTON, NY 11743

FOR OFFICE USE ONLY

Received by:_____ Date:_____ Entered by:_____ Date:_____ **IMMUNIZ1.FRM 7/03 esms**