NEW YORK UNIVERSITY
HEALTH CENTER
www.nyu.edu/nyuhc

New York University Health Center Student Immunization Record

RETURN FORM TO:
NYU Health Center • Immunization Record Services • 726 Broadway, 3rd Floor, Suite 347 • New York, NY 10003
Tel: (212) 443-1199 • Fax: (212) 443-1198

Name: ______________________________________ School: ____________________
First M.I. Last

Date of Birth: ________/________/________ Social Security #: ________-________-________
Month Day Year (School I.D.)

*** Persons born before January 1, 1957, are exempt from this requirement & 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.____ Immunized on or after first birthday AND on or after January 1, 1969 _____/_____/_____

D: RUBELLA (German Measles)
1.____Has report of adequate immune titer - **MUST SUBMIT COPY OF LAB REPORT** _____/_____/_____
2.____Immunized on or after first birthday AND on or after January 1, 1969 _____/_____/_____

NOTE: Retain a copy of this form for your records. Copies will not be provided by NYUHC.

PLEASE NOTE: THIS FORM WILL NOT BE ACCEPTED IF THIS SECTION IS NOT COMPLETED IN IT'S ENTIRETY!

Healthcare Provider Name (MD, NP, RN):______________________________
Please Print

Signature: ______________________________ **Date:** ____________

Healthcare Provider Stamp or Office Stamp for Address: ______________________________

Telephone: ____________________ **Lic #:** ____________________