SYRACUSE UNIVERSITY HEALTH SERVICES

111 WAVERLY AVENUE
SYRACUSE NY 13244-2320
Phone: 315/443-2666 Fax: 315/443-9010

IMMUNIZATION FORM

You are responsible for returning these forms in their entirety to Health Services by June 15, 2011.
We suggest that you keep a copy for your records.

PART 1: GENERAL INFORMATION - TO BE COMPLETED BY THE STUDENT

Full Legal Name: ____ Date: ____________
Last (or family) First Middle (or maiden)

Date of Birth: ____________________ Gender: ________

Home Address: ____
Number & Street City State Zip Code Country

Home Telephone: _____/____________Student Cell Phone: _____/____________
Area Code Area Code

Birthplace: ____________________

NEXT PAGE IS TO BE COMPLETED AND SIGNED BY A HEALTH CARE PRACTITIONER
(or supply equivalent information on separate form)

Syracuse University policy in accordance with New York State public health law requires all students to provide:

- Proof of immunity to measles, mumps, and rubella:
  - Dates of two doses of measles vaccine *after one year of age,* **OR** positive titer results, **OR** physician documentation of disease, and:
  - Date of one doses of rubella vaccine, or positive titer result, and;
  - Date of one dose of mumps vaccine, or positive titer results, or physician documentation of disease.

  Note: Persons born before January 1, 1957 are exempt from the measles, mumps and rubella requirements.

- Proof of immunity to meningitis or a completed response related to meningococcal meningitis vaccine indicating that the student has either been immunized within the preceding ten years or has opted not to obtain immunization against meningococcal disease.

On the *next page*, please provide exact dates (month/day/year) for all applicable immunizations and have a health care practitioner sign (or, as stated above, leave blank and provide records separately).

MANDATORY IMMUNIZATION REQUIREMENTS

MEASLES/MUMPS/RUBELLA

MMR 1st injection: _____/_____/_____

MMR 2nd injection: _____/_____/_____

Measles 1st injection: _____/_____/_____

Measles 2nd injection: _____/_____/_____

Mumps injection: _____/_____/_____

Rubella injection: _____/_____/_____

Serologic Evidence Dates: Result

Measles Titer: _____/_____/_____ Pos Neg

Mumps Titer: _____/_____/_____ Pos Neg

Rubella Titer: _____/_____/_____ Pos Neg

Disease Dates

Measles: _____/_____/_____

Mumps: _____/_____/_____

MENINGITIS

Students wishing to reduce their risk of meningococcal disease should consider receiving the meningitis vaccine. The vaccine is available at SU Health Services. Information about the disease and the vaccine is available at *students.syr.edu/health.*

Select Option 1 or Option 2 (select Option 2 even if you anticipate obtaining the vaccine at a later date):

☐ Option 1 – I received a meningococcal meningitis vaccine on: _____/_____/_____ (must be within the preceding ten years)

☐ Option 2 – To date, I have opted not to obtain meningitis vaccine (must sign):

Student Signature:

______________________________ Date: __________

Parent/Guardian Signature (if student is under age 18):

______________________________ Date: __________

OTHER

TUBERCULOSIS SCREENING

INTERNATIONAL STUDENTS MUST have tuberculosis screening done at Syracuse University Health Services upon arrival to campus in accordance with guidelines from the American College Health Association even if prior screening has been performed.

All students:

***If* screening for tuberculosis has been performed recently, please provide the following information if available:**

PPD placed date: _____/_____/_____

PPD read date: _____/_____/_____

PPD result: _____ mm x _____ mm

Chest X-ray date: _____/_____/_____

Chest X-ray result: ________________

Hep B 1st injection: _____/_____/_____

Hep B 2nd injection: _____/_____/_____

Hep B 3rd injection: _____/_____/_____

Hep A 1st injection: _____/_____/_____

Hep A 2nd injection: _____/_____/_____

Hep A+B 1st injection: _____/_____/_____

Hep A+B 2nd injection: _____/_____/_____

Hep A+B 3rd injection: _____/_____/_____

Tetanus Booster: _____/_____/_____

Polio: _____/_____/_____

Varicella 1st injection: _____/_____/_____

Varicella 2nd injection: _____/_____/_____ Result

Varicella Titer: _____/_____/_____ Pos Neg

Varicella Disease: _____/_____/_____

I hereby attest to the accuracy of the information given:

HEALTH CARE PRACTITIONER'S SIGNATURE ____________________________________ DATE _________

(or leave blank and provide equivalent information on separate form)