**MANDATORY IMMUNIZATION FORM**

Last Name: First Name: Middle:

City/State/Zip:

Date of Birth: Social Security #:

Phone: Gender: (Circle One) Male Female

**MMR COMBO (Measles, Mumps, Rubella) Two Doses** OR One Dose and Positive Titer, OR Statement from Physician of History of Having Disease, OR Proof of Honorable Discharge from Military.

Note: Proof of Attendance in US School since 1980 is Valid For 1 Dose.

1) \_\_\_\_ /\_\_\_\_ /\_\_\_\_ (date) Given at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_ /\_\_\_\_ /\_\_\_\_ (date) Given at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEPATITIS B VACCINE: Three doses.

1) \_\_\_\_ /\_\_\_\_ /\_\_\_\_ (date) Given at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_ /\_\_\_\_ /\_\_\_\_ (date) Given at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_ /\_\_\_\_\_ /\_\_\_\_ (date) Given at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**TUBERCULIN SKIN TEST**  
This test is to certify that the above-named individual is free of active tuberculosis.

This is based on A **TUBERCULIN SKIN TEST** GIVEN ON indicating **mm.**

**Signature M.D. or Nurse Printed Name Date**

*In the event of allergic reaction to TB skin test or a positive skin test result, a chest x-ray or medical doctor’s evaluation is required to rule out active tuberculosis.*

**Date of Chest X-Ray/Physician Assessment:**

**Findings:**

**Signature M.D. or Nurse Printed Name Date**

**STATEMENT OF GOOD HEALTH**

I hereby certify that is in good health based on my assessment today.

**Signature M.D. or Nurse Printed Name Date**

Address Phone Number

City, State, Zip

**MENINGOCOCCAL MENINGITIS RESPONSE FORM**

Failure to complete the following will result in being unable to attend **CURE. THIS LAW APPLIES TO ALL STUDENTS.**

New York State Public Health Law 2167 requires that all college, university, and proprietary school students, complete the following form and be provided with information regarding Meningococcal Meningitis:

Means of transmission  
Benefits, Risks and Effectiveness of Immunization  
Availability and Cost of Immunization

I, acknowledge receipt of the above information.

(print name)

I understand the material that has been provided to me by **CURE**, and will make an informed decision about being vaccinated for **Meningococcal Meningitis.**

**Check one box and sign below.**  
**I have (for students under the age of 18: My child has):**□ Had meningococcal meningitis immunization within the past 10 years. Date: \_\_\_\_\_\_\_\_\_)

[Note: If you (your child) received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine’s protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.]

□ Read, or have had explained to me, the information regarding meningococcal meningitis  
disease. I (my child) will obtain immunization against meningococcal meningitis **within 30  
days** from my private health care provider or another authorized medical provider.

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

Signed Date   
(Parent / Guardian if student is a minor)  
Print Student’s name Date of Birth

Student Mailing Address

Student E-mail address Student SS #

Student Phone Number