KINGSBOROUGH COMMUNITY COLLEGE ★ DREAMS BEGIN HERE ★ | CUNY

Health Center
2001 Oriental Boulevard, Room. A108
Brooklyn, New York 11235
P # (718) 368-5684, F # (718) 368-5024

IMMUNIZATION RECORD

Name: (Last)_____ (First)_____

Address:_____ Date of Birth: _____/_____/_____
(including City & State)

Phone: _____ Empl#: _____ Sex: ___ Male ___ Female

***NYS Public Health Law 2165 now requires post-secondary students to show protection against measles, mumps and rubella.
Persons born prior to January 1, 1957 are exempt from this requirement***

REQUIRED: **Measles (Rubeola) Immunity** – Must have one of the following:

1. TWO dates of Measles Immunization: (1) _____ (2) _____
   All doses must have been given on or after 01/01/68. The first dose must have been given on or after the first birthday and the second dose given at least 30 days after the first dose, but not before 15 months of age.

2. Measles Titer (Lab Report Required): _____ Results: _____ _____
   Date of Titer Immune Not Immune

REQUIRED: **Rubella (German Measles) Immunity** – Must have one of the following:

1. Date of one Rubella Immunization: _____
   The dose must have been given on or after 01/01/69 and on or after the first birthday.

2. Rubella Titer (Lab Report Required): _____ Results: _____ _____
   Date of Titer Immune Not Immune

REQUIRED: **Mumps Immunity** – Must have one of the following:

1. Date of one Mumps Immunization: _____
   The dose must have been given on or after 01/01/69 and on or after the first birthday.

2. Mumps Titer (Lab Report Required): _____ Results: _____ _____
   Date of Titer Immune Not Immune

DATES OF MMR: 1. _____ **2.** _____ **(Given 30 days apart)**

******To Be Completed By Health Care Provider******

_____ _____ _____
Name of Physician (print and stamp) Date Signature of Physician

_____ _____
Address Telephone Number

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

Check one Box and Sign below.

- ☐ I have read the attached information and I received the MCV4 vaccine at age 16 years or older on:
  _____/_____/_____
  mm dd yyyy
- ☐ I have read the attached information, I understand the risks of not receiving the vaccine, and I **will not** receive the vaccine.
- ☐ I (my child) will obtain immunization against Meningococcal disease **within 30 days** from my private health care provider or other facility.

Signed _____ Date _____
(Student)

Signed _____ Date _____
(Parent/Guardian if student is a minor)

Rev 11/2019

LAST NAME

FIRST NAME