

TO THE HEALTH CARE PROVIDER:**INSTRUCTIONS FOR COMPLETING THE IMMUNIZATION INFORMATION**

Please complete the form fully. Signatures of the health care provider certify that all information about the immunizations and tests is accurate. N.Y.S. Public Health Law #2165 requires that all full-time students born on or after 1/1/57 be immunized against measles, mumps, and rubella. If the New York State requirements are not met, the student will be withdrawn from school.

NOTE: All submissions must be in English. You may attach a complete immunization record in lieu of completing this form.

TUBERCULOSIS TESTING: All entering students must complete an online tuberculosis risk factor assessment and undergo TB testing only if indicated.

NEW YORK STATE IMMUNIZATIONS REQUIREMENTS INCLUDE:

- **MEASLES:** Students must receive **two** shots of live vaccine, with the first one given *no earlier than* four days before their first birthday **and** the second at least 28 days after the first dose.
- **MUMPS and RUBELLA:** Students must receive a single dose of each *no earlier than* four days prior to their first birthday.

You must give the month/day/year for each slot, and initial to the right of each date. This date can be certified by physician/nurse signature or by copy of official documents certifying what injections were given and when.

The requirements can also be met by providing a copy of a lab report demonstrating protective antibody titer.

NOTE: A second measles shot is still needed if the MMR vaccine is the only vaccine the student has received. (This can be another MMR or a single measles shot.)

RECOMMENDED IMMUNIZATIONS FOR ALL INCOMING STUDENTS:

The US Center for Disease Control and Prevention and the American College Health Association recommend the following vaccines for all incoming college students:

- **TETANUS/DIPHTHERIA/ACELLULAR PERTUSSIS (Tdap)**
- **HEPATITIS B VACCINE** – 3 dose series
- **MENINGOCOCCAL QUADRIVALENT VACCINE** – 2 doses if initial dose is given prior to age 16
- **MENINGOCOCCAL SEROGROUP B VACCINE** – 2 or 3 dose series
- **VARICELLA VACCINE** – 2 doses
- **HPV VACCINE** – 2 or 3 dose series

TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL

Patient Name: _____ DOB: _____

IMMUNIZATION RECORD DATES MUST BE WRITTEN MO/DAY/YR	Date vaccine given. Please see back for detailed instructions	Initials of certifying health professional	Serology date/results (copy of lab report MUST be attached)
COVID (REQUIRED) (1 shot J&J OR 2 shots Moderna and Pfizer)	Month Day Year #1		
	#2		
COVID BOOSTER	Month Day Year #1		
	#2		
MMR (REQUIRED)	Month Day Year #1		
	Month Day Year #2		
or MEASLES (REQUIRED)	Month Day Year #1		
	#2		
or MUMPS (REQUIRED)	Month Day Year		
or RUBELLA (REQUIRED)	Month Day Year		

THE FOLLOWING ARE RECOMMENDED BUT NOT REQUIRED FOR ADMISSION (please provide dates as applicable)

VARICELLA	Month Day Year #1		Serology date/results (copy of lab report MUST be attached)	Physician diagnosed disease hx (date of onset):
	#2			
HEPATITIS B	Month Day Year #1		Serology date/results (copy of lab report MUST be attached)	
	#2			
	#3			
Td Provide date of most recent	Month Day Year			
Tdap Provide date of most recent	Month Day Year			
INFLUENZA Provide date of most recent	Month Day Year			
MENACTRA	Month Day Year #1	Month Day Year #2		
	Month Day Year #1	Month Day Year #2		
BEXSERO (Meningitis Group B) OR	Month Day Year #1	Month Day Year #2		
	Month Day Year #1	Month Day Year #2		
TRUMENBA (Meningitis Group B)	Month Day Year #1	Month Day Year #2	Month Day Year #3	
HPV/GARDASIL (3 DOSES)	Month Day Year #1	Month Day Year #2	Month Day Year #3	

When all sections are completed, please mail this form or a copy of your official immunization record to the following address:

Cayuga Health at Ithaca College
ATTN: Health Certifications
953 Danby Road
Ithaca, NY 14850

THE FOLLOWING ARE FOR ADDITIONAL INFORMATION (please provide dates as applicable).

YELLOW FEVER	Month Day Year				
TYPHOID – circle one ORAL OR INJECTABLE	Month Day Year				
PNEUMOCOCCAL Circle one – PCV13 or PPSC23	Month Day Year #1	Month Day Year #2			
	Month Day Year #1	Month Day Year #2			
HEPATITIS A (2 DOSES)	Month Day Year #1	Month Day Year #2			
POLIO (4 or 5 DOSES)	Month Day Year #1	Month Day Year #2	Month Day Year #3	Month Day Year #4	Month Day Year #5

If you have questions, please contact the Health Center at
IChealth@cayugahealth.org
607-274-1334 (phone) or
607-274-1844 (fax)