

TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL
(See detailed instructions on the back of this form)

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)
MMR (REQUIRED)	month day year #1		
	month day year #2		
or MEASLES (REQUIRED)	month day year #1		
	month day year #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):
	month day year #2			
HEPATITIS B	month day year #1		Serology date/results (copy of lab report MUST be attached)	
	month day year #2			
	month day year #3			
Td Provide date of most recent	month day year		When all sections are completed, please mail this form or a copy of your official immunization record to the following address: Ithaca College, Hammond Health Center, ATTN: Health Certifications, 953 Danby Road, Ithaca, N.Y. 14850	
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		
MENVEO	month day year #1	month day year #2		
BEXSERO (Meningitis Group B) OR	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	

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

YELLOW FEVER	month day year		If you have questions please contact Jenna Niedermaier at healthcertifications@ithaca.edu, 607-274-1334 (phone) or 607-274-1844 (fax)		
TYPHOID – circle one <i>ORAL or INJECTABLE</i>	month day year				
PNEUMOCOCCAL circle one - PCV13 or PPSV23	month day year	month day year			
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

FOR INTERCOLLEGIATE ATHLETES ONLY: Please submit a copy of sickle cell trait testing results along with this form.

Certifying signature: _____ **Date:** _____

Name of physician or healthcare facility: _____ Phone #: _____

Street: _____ City: _____ State: _____ Zip: _____

**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 IMMUNIZATION REQUIREMENTS INCLUDE:

- **MEASLES:** Students must receive **two** shots of live virus 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 shot, **and** initial on the line 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