Cayuga HEALTH

ITHACA COLLEGE
Student Health Services

IMMUNIZATIONS RECORDS: Medical Provider Documentation

INSTRUCTIONS

Step 1: Ask your health care provider to complete and sign this form. NOTE: If you have comparable official records from your health care provider, school, or military, you may submit those rather than using this form.
Step 2: Once you have your records, go to myICHealth, and select the "Medical Clearance" section from the menu.
Step 3: Enter your immunization information on your "Medical Clearance" list.
Step 4: Select "Upload Immun. Records" to provide a copy of this form OR other comparable official records.

Student name *(last, first, middle)* _____

Date of birth *(mm-dd-yy)* _____ **Ithaca College ID #** _____

REQUIRED IMMUNIZATIONS

Students taking 6 or more credits in in-person classes must provide this completed form signed by your health care provider or comparable official records that indicate the dates you received the following immunizations.

1. Measles/Mumps/Rubella **(Complete Option 1 or Option 2)**

Option 1: Two doses of live MMR administered **on or after the first birthday** (must have been given at least 28 days apart.)
Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____

Option 2: If vaccines were given separately, select one each for Measles, Mumps, and Rubella.

Measles (Check one box only)
☐ Two doses of live vaccine administered **on or after the first birthday** (must have been given at least 28 days apart.)
Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____
☐ Protective antibody titer Date *(mm-dd-yy)* _____ Lab ☐ positive ☐ negative
☐ Physician-diagnosed illness Date *(mm-dd-yy)* _____

Mumps (Check one box only)
☐ Two doses of live vaccine administered **on or after the first birthday**
Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____
☐ Protective antibody titer Date *(mm-dd-yy)* _____ Result: ☐ positive ☐ negative
☐ Physician-diagnosed illness Date *(mm-dd-yy)* _____

Rubella (Check one box only) (Previous clinical diagnosis of rubella is not sufficient)
☐ One dose of live vaccine administered on or after the first birthday
Date *(mm-dd-yy)* _____
☐ Protective antibody titer Date *(mm-dd-yy)* _____ Result: ☐ positive ☐ negative

2. Meningococcal **(Complete Option 1, 2, or 3)**

Option 1: **Meningococcal conjugate vaccine:** including Menactra™**,** Menveo™, Menomune™, Meningococcal ACYW-135, or other (the date of your conjugate vaccine should be within the past 5 years)

☐ Meningococcal type/brand (if known) _____ Date *(mm-dd-yy)* _____

Option 2: **Meningococcal Type B**

☐ Trumenba™ Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____ Date #3 *(mm-dd-yy)* _____
☐ Bexsero™ Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____

Option 3: **Meningococcal waiver**

☐ I have decided not to obtain the meningococcal vaccine. I understand I must submit a waiver documenting my decision.
(Log in to myICHealth, go to the Downloadable Forms tab, then download, complete, and upload the Meningococcal Vaccine Waiver Form.)

RECOMMENDED IMMUNIZATIONS

If you have had any of the vaccines below, please provide the dates and have your health care provider sign this form.

These immunizations are recommended by the U.S. Centers for Disease Control and Prevention (CDC) and the American College Health Association. To protect your health, we urge students to receive these important vaccinations (or begin the series) before starting at Cornell. Please provide dates.

Tetanus If your Tdap vaccine was more than 10 years ago, you must enter a more recent tetanus booster. Check one box only. Date must be within the past 10 years.

- ☐ Tdap Date *(mm-dd-yy)* _____
- ☐ Td-adult Date *(mm-dd-yy)* _____
- ☐ Tetanus toxoid Date *(mm-dd-yy)* _____

Varicella (Chicken Pox) (Check all that apply) If you were born in the U.S. before 1980, this requirement does not apply.

- ☐ Two doses of vaccine administered on or after the first birthday (must have been given at least 28 days apart):
  Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____
- ☐ Protective antibody titer: Date *(mm-dd-yy)* _____
- ☐ Physician-diagnosed illness: Date *(mm-dd-yy)* _____ Result: ☐ positive ☐ negative

Hepatitis A Vaccine

Date #1 *(mm-dd-yy)* _____

Hepatitis B Vaccine

Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____ Date #3 *(mm-dd-yy)* _____

HEP A / HEP B Combined Vaccine

Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____ Date #3 *(mm-dd-yy)* _____

Human Papillomavirus (HPV) Vaccine Series *(Recommended for students of all genders, 26 and under)*

Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____ Date #3 *(mm-dd-yy)* _____

3. Pertussis (Tdap)

- ☐ Tdap administered age 10 or later Date *(mm-dd-yy)* _____

OTHER IMMUNIZATIONS

If you have had any of the vaccines below, please provide the dates and have your health care provider sign this form.

COVID-19 Vaccine

Type/brand _____ Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____

Rabies Vaccine

- Date #1 *(mm-dd-yy)* _____ ☐ RabAvert ☐ Imovax ☐ Unknown
- Date #2 *(mm-dd-yy)* _____ ☐ RabAvert ☐ Imovax ☐ Unknown
- Date #3 *(mm-dd-yy)* _____ ☐ RabAvert ☐ Imovax ☐ Unknown

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE

Signature _____ Date *(mm-dd-yy)* _____

Name _____ Work Phone _____
last, first, middle *degree/title*

Address _____

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Student Health Services

TO HEALTH CARE PROVIDER:

INSTRUCTIONS FOR COMPLETING THE IMMUNIZATION INFORMATION

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.

Please complete the form fully. Signature and stamp of the health care provider are necessaary to certify that all information about the immunizations and tests are accurate. A signed and stamped copy of your immunization record from your provider will be accepted as well.

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

Medical offices must add the month/day/year for each immunization. This information can be ceritfied by physician stamp and signature or by copy of official documents certifying what injections were given and when.

NEW YORK STATE IMMUNIZATIONS REQUIREMENTS:

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.

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 (NOT REQUIRED):

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 1 Dose(within the last 5 years)

MENINGOCOCCAL QUADRIVALENT VACCINE - 2 doses if initial dose is given prior to age 16 (within the last 5 years)

OR

MENINGOCOCCAL SEROGROUP B VACCINE - 2 or 3 dose series (within the last 5 years)

VARICELLA VACCINE- 2 doses

HPV VACCINE - 2 or 3 dose series

Covid

Hepititis A