KINGSBOROUGH COMMUNITY COLLEGE

Office of Health Services
2001 Oriental Boulevard
Brooklyn, New York 11235

IMMUNIZATION RECORD

Name: (Last)_____ (First)_____

Address:_____ Date of Birth: ____/____/____

Phone: _____ SSN: _____ 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***

LAST NAME

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

FIRST NAME

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 (for students under the age of 18: My child has):

❑ received the meningococcal meningitis immunization within the past 10 years. Date received: _____

❑ received the information regarding the meningococcal meningitis disease and vaccine I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

Signed _____ Date _____
(Student)

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