

NORTH COUNTRY COMMUNITY COLLEGE STUDENT IMMUNIZATION RECORD FORM

The form is required from **ALL** students taking 6 or more credit hours. If a documented record has previously been placed on file with the Records Office, please just fill out your name, social security number, and the date it was placed on file.

SECTION 1 (Please print)

Name: _____ Social Security #: _____
Address: _____ Other Names Used: _____
City/State/Zip: _____ Date of Birth: _____ / _____ / _____
Month Day Year

SECTION 2: TO BE COMPLETED AND SIGNED BY STUDENT IF 18 OR OVER. IF STUDENT IS YOUNGER THAN 18, PARENT OR GUARDIAN MUST SIGN.

MENINGOCOCCAL:

CHECK ONE (1) BOX ONLY:

Menomune™ (Quadrivalent polysaccharide) vaccine within the last 5 years DATE RECEIVED: _____ / _____ / _____
Month Day Year

Menactra Vaccine™ (Quadrivalent Conjugate) vaccine within the last 10 years DATE RECEIVED _____ / _____ / _____
Month Day Year

Health Practitioner/Physician Signature: _____ Date: _____

Name & Address Stamp of Health Practitioner/Physician: _____

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks or not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal/ meningitis disease.

Signed: _____ Date: _____ / _____ / _____
Student Signature or Parent or Guardian Signature *if student under 18 yrs.* Month Day Year

() **Copy of MMR immunization on file previously** Date previously attended NCCC: _____

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

SECTION 3: Must be signed by health practitioner.

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

1. TWO dates of Measles Immunization: (1) _____ (2) _____

Both must be given after 1967 AND on or after the first birthday.

OR

2. Date of Measles Titer _____ Results _____ (Submit a copy of the actual lab report to verify results)

OR

3. Date of physician diagnosed Measles disease _____ AND signature of the diagnosing physician _____

♦ **REQUIRED: Mumps Immunity** - Must have one of the following:

1. Date of at least ONE Mumps Immunization: (1) _____ (2) _____

Must be on or after the first birthday.

OR

2. Date of Mumps Titer _____ Results _____ (Submit a copy of the actual lab report to verify results)

OR

3. Date of physician diagnosed Mumps disease _____ AND signature of the diagnosing physician _____

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

1. Date of at least ONE Rubella Immunization: (1) _____ (2) _____

Must be on or after the first birthday.

OR

2. Date of Rubella Titer _____ Results _____ (Submit a copy of the actual lab report to verify results)

NOTE: Physician diagnosis is NOT acceptable.

Signature of Health Practitioner

Date

Printed Name of Health Practitioner

Title

Complete Address (Street, City, State, Zip)

Phone Number with Area Code

RETURN COMPLETED IMMUNIZATION RECORD FORM TO THE NCCC RECORDS OFFICE. FAILURE TO SUBMIT REQUIRED DOCUMENTS ON TIME WILL RESULT IN DISMISSAL.

REV RO 11/05