Cayuga HEALTH | ITHACA COLLEGE Student Health Services

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 If the New York State requirements are not met, the student will be withdrawn from school.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

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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)**	
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		
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			
TYPHOID – circle one *ORAL OR INJECTABLE*	Month Day Year			
PNEUMOCOCCAL Circle one – PCV13 or PPSC23	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

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

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

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Certifying Signature: _____ Date: _____

Name of Provider or Healthcare Facility: _____ Phone: _____

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