

BRING THIS FORM TO YOUR MEDICAL PROVIDER.

PLEASE NOTE YOU MUST SHOW YOU HAVE ONE OF THE FOLLOWING:

1. (2) MMR Vaccines (The first vaccination cannot be more than 4 days before your first birthday.)
2. Evidence of immunity by history of disease for measles or mumps only and proof of immunity by vaccination or blood test to rubella
3. Serological evidence for measles, mumps, and rubella (blood test proving immunity) – **copy of lab report required.**

If you are an undergraduate student 22 years of age or older, graduate student, or McGhee student, the Meningococcal Vaccine is optional. To opt out, you must complete [this form](#).

FOR MORE DETAILS, PLEASE VISIT:
www.nyu.edu/health/requirements

QUESTIONS OR CONCERNS?

Email health.requirements@nyu.edu or call (212) 443-1199



STUDENT IMMUNIZATION HISTORY FORM

Name: _____ School: _____

Date of Birth: ____/____/____ University I.D. Number: N
MM DD YY

To be in compliance you must have both items in section 1 or one each of the following in sections 2, 3, and 4 and a vaccination against Meningitis (unless eligible to decline), section 5

For more information please visit nyu.edu/health/requirements

1. M.M.R. (Measles, Mumps, Rubella) If given instead of individual immunization

Dose 1 Immunized on or after first birthday AND on or after January 1, 1972

____/____/____
MM DD YY

Dose 2 Immunized 15 months after birth or later AND at least 28 days after first dose

____/____/____
MM DD YY

2. MEASLES (RUBEOLA)

Dose 1 Immunized on or after first birthday AND on or after January 1, 1968

____/____/____ AND
MM DD YY

Dose 2 Immunized 15 months after birth or later AND at least 28 days after first dose

____/____/____
MM DD YY

Physician-diagnosed history of disease

____/____/____
MM DD YY

Has report of positive (reactive) immune titer
MUST SUBMIT COPY OF LAB REPORT

____/____/____
MM DD YY

3. MUMPS

Dose 1 Immunized on or after first birthday AND on or after January 1, 1968

____/____/____ AND
MM DD YY

Dose 2 Immunized at least 28 days after first dose

____/____/____
MM DD YY

Physician-diagnosed history of disease

____/____/____
MM DD YY

Has report of positive (reactive) immune titer
MUST SUBMIT COPY OF LAB REPORT

____/____/____
MM DD YY

4. RUBELLA (German Measles)

Dose 1 Immunized on or after first birthday AND on or after January 1, 1968

____/____/____ AND
MM DD YY

Dose 2 Immunized at least 28 days after first dose

____/____/____
MM DD YY

Has report of positive (reactive) immune titer
MUST SUBMIT COPY OF LAB REPORT

____/____/____
MM DD YY

5. MENINGOCOCCAL VACCINE (on or after your 16th birthday)

Immunization

Date ____/____/____
MM DD YY

Menveo Mencevax Menactra Other _____

