



Immunization Form for FIT Students

This form is required and must be completed in full. All information is confidential and for Health Services use only.

Name
Last
First
Middle

Personal information
Birth date
Sex <input type="radio"/> F <input type="radio"/> M
Student ID number

Immunizations

MMR and meningitis: The New York State Legislature has passed legislation requiring certain immunizations for college and other post-secondary students. **In order to attend classes, all students must provide proof of immunity against measles, rubella, and mumps.** Students born prior to January 1, 1957, are exempt from these requirements. For the purposes of the college MMR immunization law, proof of immunity for measles, rubella, and mumps shall mean the following:

Measles (rubeola): Two doses of live measles vaccine given on or after the first birthday and after 1967, physician documented history of disease, or serological evidence of immunity.

Rubella (German measles): One dose of live virus rubella vaccine given on or after the first birthday, or serological evidence of immunity.

Mumps: One dose of live mumps vaccine given on or after the first birthday, physician documented history of disease, or serological evidence of immunity.

Applicants should consult parents, doctors, a former high school nurse, or a public health clinic to obtain copies of their immunization records. Immunization records should be reviewed with a health care provider.

To avoid jeopardizing your enrollment, complete this immunization form and return it to Health Services promptly.

If you have any questions, call Health Services at 212 217.4190.

Measles (rubeola) immunity
Must have one of the following:
1. Two dates of measles immunization
<i>Must be given after 1967 and on or after the first birthday</i>
/ /
/ /
2. Date of measles titer
/ /
Quantitative results: <input type="radio"/> Positive <input type="radio"/> Negative
3. Date of physician-diagnosed measles disease
/ /
and signature of the diagnosing physician

Rubella (German measles) immunity
Must have one of the following:
1. Date of rubella immunization
<i>Must be on or after the first birthday</i>
/ /
2. Date of rubella titer
/ /
Quantitative results: <input type="radio"/> Positive <input type="radio"/> Negative
Physician diagnosis is not acceptable.

Mumps immunity
Must have one of the following:
1. Date of mumps immunization
<i>Must be on or after the first birthday</i>
/ /
2. Date of mumps titer
/ /
Quantitative results: <input type="radio"/> Positive <input type="radio"/> Negative
3. Date of physician-diagnosed mumps disease
/ /
and signature of the diagnosing physician

Tuberculosis
A screening test for tuberculosis: a recent (within one year) PPD and documentation of a chest X-ray for a positive PPD should be included.
1. Date of PPD (Mantoux) test within the past year (Tine or Monovac not acceptable)
/ /
Results: <input type="radio"/> Positive <input type="radio"/> Negative
MM Induration
2. Positive PPD – chest X-rays required
Date of chest X-ray
/ /
Results: <input type="radio"/> Positive <input type="radio"/> Negative
3. BCG vaccine
/ /
Date of chest X-ray (required if PPD not done)
/ /

Tetanus
1. Date of last booster
/ /

Signature and stamp of health practitioner
Date / /

Meningitis
New York State Public Health Law §2167 requires that all college and university students enrolled for at least 6 semester hours or the equivalent per semester provide the following information regarding meningococcal disease and vaccination(s). Check one and sign below:
<input type="radio"/> I had the meningococcal meningitis immunization (Menomune™) within the past ten years.
Date received: _____
<input type="radio"/> I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.
Student's signature (parent or guardian if a minor)
Date: / /



**Health Services Form
for FIT Students**

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Name

Last _____

First _____

Middle _____

Personal information

Birth date _____ / _____ / _____

Sex F M

Student ID number _____ / _____ / _____

Home address

Street _____

City _____

State, zip _____

Phone () _____

Local phone () _____

In an emergency, please notify

Name _____

Home phone () _____

Work phone () _____

Personal physician

Name _____

Street _____

City _____

State, zip _____

Phone () _____

Health insurance

Yes No

Company _____

Insured name _____

Policy # _____

Expiration date _____ / _____ / _____

Check any of the following that apply to you

Alcohol/drug use

Asthma

Cancer

Colitis

Depression

Diabetes

Eating disorder

Heart disease

High blood pressure

Kidney disease

Migraines

Peptic ulcer

Seizures

Other

List medications that you take regularly

List drug allergies

Check the following if it applies to you

Wear orthopedic devices

Use a wheelchair

Require special housing

Have severe hearing loss

Have severe vision loss

Other

Consent for medical treatment

The following statement is to be signed by the student.

The parent or guardian should also sign if the student is under 18 years of age.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my health and welfare.

Applicant's signature _____

Date _____ / _____ / _____

Parent or guardian's signature _____

Date _____ / _____ / _____

The preceding information is true and accurate to the best of my knowledge.

Applicant's signature _____

Date _____ / _____ / _____

Location

Health Services is located on the fourth floor of the David Dubinsky Student Center, Room A402, opposite the elevators.

Hours

Full services available only during fall and spring semesters. Health Services is open the following hours with coverage by a physician, a nurse practitioner, or registered nurse:

Monday to Thursday 9 am-10 pm

Friday 9 am-5 pm

Women's clinic by appointment only.