Crandall Health Center
at Alfred University

19 Park Street, Alfred, NY 14802
Phone: (607) 871.2400

OFF- CAMPUS & HIGH SCHOOL STUDENT IMMUNIZATION FORM

This is the only official accepted form

ALL STUDENTS *REGARDLESS OF AGE OR CREDIT HOURS MUST COMPLETE TOP SECTION*

Name:________________________________ Student ID #:____________________ Date of Birth: _______________

A. Meningitis Vaccination: Date Received:____________ Check One: ☐ Menactra™ ☐ Menomune™
(Recommended not required)

OR

B. If Meningitis Vaccine not received **complete** the following:

MENINGOCCAL MENINGITIS VACCINATION ACKNOWLEDGEMENT

Please read the enclosed information regarding Meningococcal Disease and the availability of a vaccination against this disease. This vaccination is available at Crandall Health Center for a cost of approximately $110 (2006-2007 school year). **Check one box and sign below:**

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease. I understand that although I have declined the vaccine at this time, I have the right to request the vaccine at any time in the future.

Student Signature (Parent, if under 18):__________________________________ Date: ______________________

C. For those born after January 1, 1957, the following must be completed **and** signed by your healthcare provider to document compliance with New York State Public Health Law 2165. The form must have the month, day, and year typed or printed in the English language. **Please note that according to NYS Public Health law, no institution shall permit any student to attend the institution in excess of 30 days without complying with this law.**

Measles (Rubeola): Two live doses of measles are required. First dose must be given after the first birthday and the second dose must be given after fifteen months of age and at least thirty (30) days after the first dose.

MMR: (Combined measles, mumps, rubella): #1 _______________ (Month/Day/Year #2 _______________ (Month/Day/Year

OR

Date of first live dose of measles given: #1 _______________ (Month/Day/Year

Date of second live dose of measles given: #2 _______________ (Month/Day/Year

OR

Date of positive measles titer: ***(Copy of actual laboratory report including reference range must be attached.)***

Mumps: (One mumps dose is required and must be given after the first birthday)

Date of mumps vaccination given: #1 _______________ (Month/Day/Year

OR

Date of positive mumps titer: ***(Copy of actual laboratory report including reference range must be attached.)***

Rubella (German Measles): (One dose is required and must be given after the first birthday)

Date of rubella vaccination given: #1 _______________ (Month/Day/Year

OR

Date of positive rubella titer: ***(Copy of actual laboratory report including reference range must be attached.)***

Healthcare Provider Signature: ____________________________________ **(Required) Date:** _______________

Mailing Address: ______________________________________ **Phone:** ______________ **Fax:** _______________

*Completed form must be received one month prior to the start of classes.