



Office of High School and Pre-College Programs
 Nexus Building, Room 104
 One South Ave.
 Garden City, NY 11530
 P 516.877.3046
 F 516.877.3039

Pre-College Program Immunization Record

GENERAL INFORMATION All information is required and entries must be written in English. Please print.

Last Name _____ First Name _____ MI _____

Preferred Name _____ DOB _____

**To comply with New York State immunization law, you must have some combination equivalent to two doses of the measles vaccine, one mumps vaccine and one rubella vaccine OR provide serological evidence of immunity (titers).*

REQUIRED IMMUNIZATIONS (To be Completed by a Healthcare Provider ONLY)

MMR (Measles, Mumps and Rubella) *If Given as a Combined Dose Instead of Individual Immunizations*

_____ Dose 1: Immunized After 1971 and NO MORE THAN 4 Days Prior to First Birthday Date ____/____/____
 _____ Dose 2: Immunized as Above AND at Least 28 Days After First Dose of MMR Date ____/____/____

OR

MEASLES *Two Doses AT LEAST 28 Days Apart, Given After 1967 and No More Than 4 Days Prior to First Birthday*

_____ Dose 1: Immunized on or After January 1, 1968 Date ____/____/____
 _____ Dose 2: Immunized as Above AND at Least 28 Days After First Dose of Measles Date ____/____/____

MUMPS One Dose After January 1, 1968 Date ____/____/____

RUBELLA (GERMAN MEASLES) One Dose After January 1, 1968 Date ____/____/____

OR

SEROLOGIC EVIDENCE OF IMMUNITY FOR EACH DISEASE

**Lab Reports Verifying Immunity (IgG) to Measles, Mumps and Rubella REQUIRED (Titers).*

_____ Lab Reports Attached

RECOMMENDED IMMUNIZATIONS FOR PRE-COLLEGE STUDENTS

TDap (Booster Recommended for ALL Students) ____/____/____ Meningococcal Vaccine ____/____/____

OR

Tetanus Toxoid (Within 10 Years) ____/____/____

Chicken Pox (Varicella) Immunization 1 ____/____/____ 2 ____/____/____ OR Date of Disease ____/____/____

Hepatitis B Series 1 ____/____/____ 2 ____/____/____ 3 ____/____/____

Hepatitis A Series (If Considering or Definitely Travelling Abroad) 1 ____/____/____ 2 ____/____/____

Gardasil Series 1 ____/____/____ 2 ____/____/____ 3 ____/____/____

Healthcare Provider's Name _____ Phone _____

Signature _____ License No.* _____ Date _____

STAMP HERE.

**This form will NOT be accepted without the healthcare provider's signature and stamp or license number if no stamp is available.*

**THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE
 OFFICE OF HIGH SCHOOL AND PRE-COLLEGE PROGRAMS BY FRIDAY, JUNE 22, 2018.
 PLEASE KEEP A COPY FOR YOUR RECORDS.**