Office of High School and Pre-College Programs
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.***