

**Baruch College  
Medical Records Unit, Located in the  
Undergraduate Admissions Office  
One Bernard Baruch Way, Box H-0721  
New York NY 10010  
Tel: (646) 312-1400 Fax: (646) 312-1362 or 1363**

**IMMUNIZATION RECORD**

**Proof of Immunization is required prior to registration. Please be sure to complete both sides of the form and return it to the Undergraduate Admissions Office, Room 720.**

**Part I: To Be Completed By The Student**

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Day Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

Address \_\_\_\_\_  
Street City State Zip

**Part II: To Be Completed And Signed By Student or Parent / Guardian For Student Under The Age Of 18**

**MENINGOCOCCAL MENINGITIS:**

**Please review the attached information regarding the meningococcal disease.**

CHECK ONE (1) BOX ONLY THE SIGN BELOW:

- Had the Meningococcal Meningitis Immunization (Menomune) within the past 10 years.  
Date Received: \_\_\_\_\_  
Month / Year

(NOTE: The Vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years)

- 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian if student is under the age of 18)

Meningococcal disease is a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, Governor Pataki signed New York State Public Health Law (NYS PHL) §2167 requiring institutions, including colleges and universities, to distribute information about Meningococcal disease and vaccination to all students meeting the enrollment criteria, whether they live on or off campus. This law became effective on August 15, 2003 (prior to the Fall 2003 semester).

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States (types A, C, Y and W-135). These types account for nearly two thirds of meningitis cases among college students. To learn more about meningitis and the vaccine, please consult your (child's) physician. You can also refer to the following websites: The New York State Department of Health [www.health.state.ny.us](http://www.health.state.ny.us); The Center for Disease Control and Prevention [www.cdc.gov/ncidod/dbmd/diseaseinfo](http://www.cdc.gov/ncidod/dbmd/diseaseinfo); or The American College Health Association [www.acha.org](http://www.acha.org).

**Please Complete The Other Side Of The Page** ⇨

**Measles / Mumps / Rubella (MMR)**  
**Information**

**Part III. To Be Completed And Signed By A Health Care Provider**

The New York State Department of Health has recommended that if a second dose of measles vaccine is needed, a combined MMR vaccination be given to ensure additional protection against rubella and mumps.

**The following are requirements based on N.Y.S Immunization Law**

Check appropriate statement:

**A. MMR (Measles, Mumps, Rubella) if given as a combined dose instead of individual immunizations.**

- 1. Dose 1- Immunized after 1972 (and after 12 months of age). ..... \_\_\_/\_\_\_/\_\_\_
- 2. Dose 2- 30 days or more after Dose 1 (and after 15 months of age)..... \_\_\_/\_\_\_/\_\_\_

**B. Measles (Rubeola)**

- 1. Has report of immune titer. **Copy of laboratory report must be included**..... \_\_\_/\_\_\_/\_\_\_
- 2. Dose 1- immunized with live measles vac. after 1/1/68 (and after 12 months of age)..... \_\_\_/\_\_\_/\_\_\_
- 3. Dose 2- immunized with live measles vac. At least 30 days beyond dose 1..... \_\_\_/\_\_\_/\_\_\_

**C. Rubella**

- 1. Has report of immune titer. **Copy of laboratory report must be included**. .... \_\_\_/\_\_\_/\_\_\_
- 2. Immunized with live vaccine after 1/1/69 (and after 12 months of age)..... \_\_\_/\_\_\_/\_\_\_

**D. Mumps**

- 1. Has report of immune titer. **Copy of laboratory report must be included**..... \_\_\_/\_\_\_/\_\_\_
- 2. Immunized with live vaccine after 1/1/69 (and after 12 months of age)..... \_\_\_/\_\_\_/\_\_\_

**(NOTE: The New York State Board Of Health does not accept a Doctor's diagnosis for the Measles, Mumps, and Rubella (MMR). All students must provide exact dates of receiving the MMR vaccines or a copy of the immune titer.)**

**E. Medical Waiver**

If one or more required immunizations may be detrimental to the student's health or is otherwise medically contraindicated, the vaccination requirement shall be waived until such immunization is determined no longer detrimental to the student's health or otherwise medically contraindicated. A physician, physician's assistant or nurse practitioners written statement must be attached that specifies those immunizations that may be detrimental and the length of time that they are detrimental. The written statement must be submitted with a medical exemption form.

**F. Religious Exemption**

A summary of the religious beliefs, which prohibit immunization. This statement must describe the beliefs in sufficient detail to allow a determination that (a) the beliefs are religious in nature (not philosophical) and (b) the beliefs are genuinely and sincerely held.

\_\_\_\_\_

Health Care Provider (Physician or other) **Provider's Stamp And Signature Are Required**

Name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_