BARNARD

New Student Immunization Form

This section to be completed by the student:

Legal Last Name: _____ Legal First Name: _____ Middle Initial: ____

Date of Birth (MM/DD/YYYY): ___/___/_____ UNI: _____

Email Address: _____

If you indicate that you received the meningitis vaccine within the past 5 years, the medical provider must take action below. If you have not received the vaccine, please follow instructions on our how-to-guide to submit an exemption, found on our website under "new student forms".

This section must be completed by a medical provider who is not a relative:

This form will not be accepted until the following section is fully completed by a medical provider.

Measles (Rubeola), Mumps, Rubella (MMR) Upload supporting documentation to the **Patient Portal, Medical Clearances** section. All records must include name and date of birth.	**Vaccine:**	**Date: MM/DD/YYYY**
Option A MMR Immunizations (On or after first birthday and at least 28 days apart)	MMR Dose 1 MMR Dose 2	___/___/_____ ___/___/_____
Option B Measles, Mumps, and Rubella Immunizations given separately (On or after first birthday and at least 28 days apart)	Measles Dose 1 Measles Dose 2 Mumps Dose 1 Rubella Dose 1	___/___/_____ ___/___/_____ ___/___/_____ ___/___/_____
Option C Positive MMR IgG Antibody titers **(lab reports required)**	Measles (Rubeola) Titer Mumps Titer Rubella Titer	___/___/_____ ___/___/_____ ___/___/_____
Meningitis Vaccine (only if student indicated receipt of meningococcal vaccine within past 5 years)		
Option A Meningococcal type B immunizations (2 doses given at least 6 months apart within the past 5 years)	MenB Dose 1 MenB Dose 2	___/___/_____ ___/___/_____
Option B Meningococcal conjugate (ACWY) immunization (1 dose given within the past 5 years)	MenACWY Dose 1	___/___/_____
Option C Meningococcal type B immunizations (2 doses given at least 6 months apart within the past 5 years)	MenABCWY Dose 1	___/___/_____

I attest that all dates, results, and immunizations listed on this form are correct and accurate.

Medical Provider's Printed Name: _____ Date: ___/___/_____

Medical Provider's Signature & Stamp (Both required):

License Number: _____