BARNARD

MMR AND OTHER IMMUNIZATION RECORDS FORM

Please print clearly. You should also submit an official immunization record.

Section A: This section is to be completed by the student	
Name: (last) (first)	
Barnard Uni:	Cell phone #:
I will reside on campus (circle one): Yes No	Date of Birth: / /

Section B: REQUIRED VACCINATIONS AND/OR PROOF OF IMMUNITY

for Measles, Mumps, Rubella (MMR): Required for ALL full & part-time students.

→ **OR** ↓	**2 doses MMR Vaccine** **Dose #1** received at or after 12 months of age: ☐☐☐ **Dose #2** received at or after 28 days from 1st dose: ☐☐☐	**OR**	**Laboratory Documentation of Immunity**
	2 doses of Measles Vaccine **Dose #1** received after 1968 and at or after 12 months of age: ☐☐☐ **Dose #2** received at or after 28 days from 1st dose: ☐☐☐	**OR**	**Measles Virus IgG Antibody Test Copy of lab report must be attached and must have reference ranges.**
	2 doses of Mumps Vaccine **Dose #1** received at or after 12 months of age: ☐☐☐ **Dose #2** received at or after 28 days from 1st dose: ☐☐☐	**OR**	**MUMPS Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached**
	1 dose of Rubella Vaccine **Dose #1** received at or after 12 months of age: ☐☐☐	**OR**	**RUBELLA Virus IgG Antibody test demonstrating immunity. Copy of the laboratory report must be attached.**

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Section C: STRONGLY RECOMMENDED VACCINATIONS

MENINGITIS VACCINE

Meningococcal A, C, W, Y (MenACWY): Menactra® or Menveo®

Dose #1
One dose required if given after 16th birthday:

Dose #2
Required if 1st dose given prior to age 16. If 1st dose is received at 11-12 years of age, 2nd dose required is at age 16. If 1st dose given between age 13 - 15, 2nd dose must be given between age 16 – 18.

Meningococcal B (MenB): Bexsero® or Trumemba® (2) or (3) dose series: Optional and recommended for all students in a high-risk group and anyone age 16-23 years.

Trumenba

Dose #1

Dose #2

Dose #3

OR

Bexsero

Dose #1

Dose #2

COVID-19 VACCINE AND BOOSTER(S)

Double Dose Primary Vaccinations

Dose #1

Dose #2

Vaccine Manufacturer:
_____

OR

Single Dose Primary Vaccination

Dose #1

Vaccine Manufacturer: _____

COVID-19 Booster Vaccinations

Booster #1 **Booster Manufacturer:** _____

Booster #2 **Booster Manufacturer:** _____

Booster #3 **Booster Manufacturer:** _____

Influenza Vaccine **Last Administration Date:**

Pneumococcal Vaccine: **Dose #1** **Dose #2**

STRONGLY RECOMMENDED VACCINATIONS CONTINUE ON PAGE 3, THE NEXT PAGE

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HEPATITIS A		
Dose #1 ☐☐☐ Dose #2 ☐☐☐	OR	Upload official laboratory report indicating anti-HBC titers with immunization record.

HEPATITIS B		
Dose #1 ☐☐☐ Dose #2 ☐☐☐ Dose #3 ☐☐☐	OR	Upload official laboratory report indicating anti-HBC titers with immunization record.

HUMAN PAPILLOMA VIRUS (HPV)

Dose #1 ☐☐☐ Dose #2 ☐☐☐ Dose #3 ☐☐☐ (if indicated)

TETANUS, DIPTHERIA, PERTUSIS		
TDAP: ☐☐☐	OR	TD: ☐☐☐

VARICELLA (CHICKEN POX)		
Dose #1 ☐☐☐ Dose #2 ☐☐☐	OR	Or provide lab report showing positive IgG antibody titer

POLIO VACCINE

Up to date (received all required doses. Please circle one) Yes No

This form must be signed, dated, and stamped by an MD, DO, NP, PA	
Provider's Printed Name: _____ Provider's Signature: _____ Date: ☐☐☐	PROVIDER STAMP HERE: Form not valid without provider stamp