STUDENT IMMUNIZATION REPORT

Return to: Bank Street College, Office of the Registrar
610 West 112th St., New York, NY 10025
Fax: 212-875-4677

Name _____ Social Security # _____

Address _____ Date of Birth _____

In order to register for classes, **all matriculated students** (and non-matriculated students taking 6 credits or more) are **required by New York State Law** to provide the information requested below.)

Part 1: MEASLES, MUMPS, RUBELLA (If you were born before 1/1/57, you do not have to complete Part 1.)

A. MEASLES: Students must submit 1 of the following:

1) **2** dates of measles immunization: **Date 1**_____ **Date 2** _____

or

2) 1 date of measles titer (blood test) with lab results: Date _____ Results of titer _____

or

3) 1 date of measles disease diagnosis: _____

B. MUMPS: Students must submit 1 of the following:

1) 1 date of mumps immunization: **Date** _____

or

2) 1 date of mumps titer (blood test) with lab results: Date _____ Results of titer _____

or

3) 1 date of mumps disease diagnosis: _____

C. RUBELLA: (German Measles): Students must submit 1 of the following:

1) 1 date of rubella immunization: **Date** _____

or

2) 1 date of rubella titer (blood test) with lab results: Date _____ Results of titer _____

or

3) 1 date of rubella disease diagnosis: _____

Signature of physician _____

Part 2: MENINGOCOCCAL MENINGITIS (See attached sheet regarding information on this disease.)

You are required by New York State Law to provide responses about meningitis. Check one box below.
I have:

☐ had the meningococcal meningitis immunization within the past 10 years. Date received: _____

☐ read, or have had explained to me, the information regarding meningitis disease. I will obtain immunization against meningitis within 30 days from my private health care provider or another health facility.

☐ read, or have had explained to me, the information regarding meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningitis disease.

Student Signature _____ **Date** _____

Copies of medical records may be provided in lieu of a physician's signature