

Immunization Record Form

REQUIRED OF ALL STUDENTS ENROLLING IN 6 OR MORE CREDITS

Submit this form and any required documentation (not originals) to the Health Office, located in the Student Center. Fax to 914-606-6423. This form may also be downloaded from our web site: www.sunywcc.edu/regforms

Please Print:

Name: _____ Street Address: _____
Last First M.I.-Maiden

City: _____ State: _____ Zip Code: _____ Local Phone: _____

Social Security Number (last four digits only): _____ Date of Birth: _____

Part I: Meningococcal Meningitis

For all students regardless of age, NYS Public Health Law mandates that you read and sign Part I.

Meningitis disease is a severe bacterial infection of the bloodstream or meninges (a thin layer covering the brain and spinal cord). It is a relatively rare disease and usually occurs as a single isolated event. Clusters of cases or outbreaks are rare in the United States. It is transmitted through air via droplets of respiratory secretions and direct contact with an infected person. Direct contact, for these purposes, is defined as oral contact with shared items such as cigarettes or drinking glasses or through intimate contact such as kissing. Although anyone can come into contact with the bacteria that causes meningococcal disease, data also indicates certain social behaviors, such as exposure to passive and active smoking, bar patronage, and excessive alcohol consumption, may put students at increased risk for the disease. Patients with respiratory infections, compromised immunity, those in close contact to a known case, and travelers to endemic areas of the world are also at increased risk.

The early symptoms usually associated with meningococcal disease include fever, severe headache, stiff neck, rash, nausea, vomiting, and lethargy, and may resemble the flu. Because the disease progresses rapidly, often in as little as 12 hours, students are urged to seek medical care immediately if they experience two or more of these symptoms concurrently. The disease is occasionally fatal. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. Antibiotics can be used to treat people with meningococcal disease. Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth to mouth resuscitation, day care center playmates, etc.) need to be considered for preventative treatment. Such people are usually advised to obtain a prescription for a special antibiotic from their physician. Casual contact as might occur in a regular classroom, office or factory setting is not usually significant enough to cause concern.

Presently, there is a vaccine that will protect against some strains of meningococcus. It is recommended in outbreak situations, and for those traveling to areas of the world where high rates of the disease are known to occur.

The meningococcal vaccine has been shown to provide protection against the most common strains of the disease, including serogroups A, C, Y and W-135. The vaccine has shown to be 85 to 100 percent effective in serogroups A and C in older children and adults. The vaccine is very safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to 2 days.

If you wish to receive the meningococcal vaccine, contact your health care provider. The cost of the vaccine varies but is usually around \$90. The Ossining Open Door, Tarrytown Open Door and Port Chester Open Door Facilities provide the vaccine.

PART I: MENINGOCOCCAL MENINGITIS RESPONSE

To be completed & signed by student or parent/guardian for students under age 18.

CHECK ONE (1) BOX ONLY

I (my child) had the meningococcal meningitis immunization (Menomune™) within the last 10 years.

Date Received: _____
mo day yr

I have read the information regarding meningococcal meningitis disease and I understand the risk of not receiving the vaccine. I (my child) will not obtain immunization against meningococcal meningitis disease at this time.

Signature _____

Date _____
mo date yr

Part II: Measles, Mumps & Rubella

For all students born on or after January 1, 1957, NYS Public Health Law mandates that you provide signed documentation of proof of immunity against measles, mumps & rubella on or after your first birthday. Students will not be permitted to register for classes without proof of immunization. Students who have not complied within thirty days will be withdrawn without refund, from all classes.

MEASLES – Immunization (2 injections) on or after January 1, 1968 (at least thirty days apart) or positive titer or date of physician documented disease.

Note: Immunizations before January 1, 1968 are acceptable if there is proof that live vaccine was used.

MUMPS – Immunization (1 injection) on or after January 1, 1969 or positive titer or physician documented disease.

RUBELLA – Immunization (1 injection) on or after January 1, 1969 or positive titer. (Proof of disease not acceptable.)

You may provide any health records which demonstrate proof of immunity from prior schools, physicians or a local health department. You can also be immunized by your doctor or health care provider or you can call the county health department for free immunization 914-231-2523. If you hold religious beliefs which prohibit receiving immunizations for Measles, Mumps & Rubella, contact the Health Office at 914-606-6610.

HEALTH CARE PROVIDER REQUIRED FOR PART II:

Name _____

Address _____

Signature _____

Phone _____

PART II: PROOF OF MEASLES, MUMPS & RUBELLA IMMUNITY

Must be completed and signed by a Health Care Provider.

MMR (Measles, Mumps & Rubella combined vaccine)

Two Doses Required:

Dose 1 – Must have been given on or after first birthday

Date Received _____
mo day yr

Dose 2 – Must have been given at least 30 days after Dose 1

Date Received _____
mo day yr

OR if Measles, Mumps & Rubella given as individual vaccines:

MEASLES (check one box below if applicable):

Date of positive immune titer OR

Date had disease or

Date of Dose 1: Immunization with live Measles vaccine on/after January 1, 1968 and on/or after first birthday

Date _____
mo day yr

Date of Dose 2: Immunization with live Measles vaccine on/after January 1, 1968 and on/or after first birthday

Date _____
mo day yr

If vaccinated prior to January 1, 1968, I certify live vaccine was used:

Physician's Signature: _____

MUMPS (check one box below):

Date of positive immune titer or

Date had disease

Date of live vaccine on or after January 1, 1969 & on or after 1st birthday

Date _____
mo day yr

RUBELLA (check one box below):

Date of positive immune titer

Date of live vaccine on or after January 1, 1969 & on or after 1st birthday

Date _____
mo day yr

Please circle the semester and add the year: Spring / Fall / Summer / 20_____