Please follow these directions carefully:

Attention: Due to high volume of paperwork, PLEASE do not send us this instruction sheet. We only need the immunization forms.

Accurate and complete immunization information are required for registration at Fordham University. Incomplete information may result in your registration being delayed or even blocked.

Immunization Hotline for Questions:
718-817-0940

Students: Once your health care provider has completed this form, make a copy for your records and return the original to the address listed on this sheet. Forms may be faxed to (718) 817-3218 or scanned and sent to health@fordham.edu. This form is not valid if any information is missing and will not be processed without a health care provider’s signature, stamp, and license number.

Health Care Providers: Complete all parts if patient is 18 or under. For each section, provide the date of immunization. If documenting illness, measles and mumps only must be accompanied by a letter from an MD, PA, NP. For serologic testing (titers), lab results showing immunity should also be attached. Please note the date format of Month/Day/Year (MM/DD/YY). All immunizations must have been received after the first birthday. This form will not be processed without a health care provider’s signature, stamp, and license number.

SECTION I, II, & III ARE MANDATORY

SECTION IV IS ONLY RECOMMENDED (encouraged if student has a medical condition or is on prescribed medication(s))

NEW YORK STATE VACCINATION LAW 2165 and 2167:

If a student is registered to attend for less than 6 semester hours or 4 credit hours per quarter, the immunization requirements do not apply to that student. If an enrollee at a post-secondary institution was born before 1957, he/she does not have to comply with PHI Section 2165 immunization requirements.

SECTION I. MMR: This combination vaccine is often given because it protects from Measles, Mumps, and Rubella. Two doses are required for entry into Fordham University. (1) One must have been received on or after the 1st birthday. (2) The second dose must have been received at least 28 days after the first dose and at age 15 months or greater as per NYS DOH guidelines. *MMR was not available in the U.S. before 1/1/1972.*

1. Measles (Rubella): Students born on or after January 1, 1957 must submit proof of immunity to measles. Only ONE of the following is required:
   - The student must submit proof of two doses of live measles vaccine: the first dose given no more than 4 days prior to the student's first birthday and the second at least 28 days after the first dose; or
   - The student must submit serological proof of immunity (titer) to measles. This means the demonstration of measles antibodies through a blood test performed by an approved medical laboratory; or
   - The student must submit a statement from the diagnosing physician, physician assistant or nurse practitioner that the student has had measles disease; or
   - The student must submit proof of honorable discharge from the armed services within 10 years from the date of application to the institution. The proof of honorable discharge shall qualify as a certificate enabling a student to attend the institution pending actual receipt of immunization records from the armed services; or
   - If a student is unable to access his/her immunization record from a health care provider or previous school, documentation that proves the student attended primary or secondary school in the United States after 1980 will be sufficient proof that the student received one dose of live measles vaccine. If this option is used, the second dose of measles vaccine must have been administered within one year of attendance at a post-secondary institution.

2. Mumps: Students born on or after January 1, 1957 must submit proof of immunity to mumps. Only ONE of the following is required:
   - The student must submit proof of two doses of live mumps vaccine given no more than 4 days prior to the student's first birthday; or
   - The student must submit serological proof of immunity (titer) to mumps. This means the demonstration of mumps antibodies through a blood test performed by an approved medical laboratory; or
   - The student must submit a statement from the diagnosing physician, physician assistant, or nurse practitioner that the student has had mumps disease; or
   - The student must submit proof of honorable discharge from the armed services within 10 years from the date of application to the institution. The proof of honorable discharge shall qualify as a certificate enabling a student to attend the institution pending actual receipt of immunization records from the armed services.

3. Rubella (German measles): Students born on or after January 1, 1957 must submit proof of immunity to rubella. Only ONE of the following is required:
   - The student must submit proof of one dose of live rubella vaccine: the first dose given no more than 4 days prior to the student's first birthday; or
   - The student must submit serological proof of immunity (titer) to rubella. This means the demonstration of rubella antibodies through a
If patient/student has a medically documented, previous TST (Mantoux) or IGRA, the test need not be repeated

http://apps.who.int/gho/data/view.main.57040?lang=en

Countries with a high incidence of TB (incidence of >10/100,000) are listed at the following link

For more specific information about meningococcal meningitis and college student risks, please visit the NYS DOH Website:

http://www.health.state.ny.us/nysdoh/immun/meningococcal/index.htm

SECTION II. Meningococcal Meningitis:

New York State PHL Section 2167 requires post-secondary institutions to distribute information about meningococcal disease and vaccination to the students, or parents or guardians of students under the age of 18. The institution is required to maintain a record of the following for each student:

- Certificate of Immunization for meningococcal meningitis disease; or
- A response to receipt of meningococcal meningitis disease and vaccine information signed by the student or the student’s parent or guardian; AND, EITHER
- Self reported or parent recall of meningococcal meningitis immunization within the past 10 years; or
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or student’s parent or guardian.

Information about Meningococcal Disease: College students, especially freshman living in residence halls, are at a slightly increased risk for contacting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. A vaccine is currently available that will decrease, but not completely eliminate, a person’s risk of acquiring meningococcal meningitis. This element of uncertainty remains because there are five (5) different Serotypes (A, B, C, Y, & W-135). The vaccine, Menactra™/Menomune™, probably protects for 3-5 years, and is extremely safe for use. Menactra™/Menomune™ vaccine is available at the Fordham University Student Health Center for a cost of $130.00. Also available is the vaccine for Meningitis that covers Serogroup B (Trumenba) for a cost of $155.00.

For more specific information about meningococcal meningitis and college student risks, please visit the NYS DOH Website:

http://www.health.state.ny.us/nysdoh/immun/meningococcal/index.htm

SECTION III. Tuberculosis (TB) Risk Factor Screening: Either Part A or B MUST be completed by a physician or healthcare provider.

Information about TB Screening: Universal tuberculin or Interferon Gamma Release Assay (IGRA) testing is not recommended in the U.S and other low-incidence countries due to the high rate of false positive results. Tuberculin or IGRA testing is, however, indicated for children/individuals with the following risk factors for TB:

1. History of exposure to anyone with TB
2. Immigration from a country with a high incidence of TB
3. Travel to a high-incidence country where housing was with family members or local resident-not hotels, resorts, etc.
4. Household contact with parents or others who immigrated from a country with a high incidence of TB and tuberculin status unknown (consider testing at ages 1,5,12)
5. Exposure to individuals in the past 5 years who are HIV-infected, homeless, institutionalized, users of illicit drugs, incarcerated (test all groups every 2-3 years
6. HIV infection (test yearly), diabetes mellitus, chronic renal failure, malnutrition, reticuloendothelial disease, other immunodeficiencies or receiving immunosuppressive therapy

Countries with a high incidence of TB (incidence of >10/100,000) are listed at the following link:
http://apps.who.int/gho/data/view.main.57040?lang=en. (Includes most countries of Asia, Africa, Eastern Europe, Central and Sough America)

If patient/student has a medically documented, previous TST (Mantoux) or IGRA, the test need not be repeated

SECTION IV. Recommended (not mandatory): Space is provided to record this information.

A. Tetanus-Diphtheria: booster shot within the past 10 years.
B. Hepatitis B Vaccine: It is recommended that all infants, children and adolescents up to the age of 18 receive the Hepatitis B vaccine. It is also recommended for adults who may be at high risk for infection.
C. Hepatitis A Vaccine: It is recommended that all children at 1 year old receive the Hepatitis A vaccine. Mail/Fax/E-mail Scanned Document

Fordham University Health Services, Attn: Immunizations
441 East Fordham Road, Bronx, NY 10458
Phone: 718-817-4160 Fax: 718-817-3218
E-mail: health@fordham.edu

Attention: Due to high volume of paperwork, PLEASE do not send us this instruction sheet. We only need the immunization forms.
**FORDHAM UNIVERSITY HEALTH SERVICES**

**2017-2018**

Name: ____________________________________________

<table>
<thead>
<tr>
<th>Fordham ID #: A __________________________</th>
</tr>
</thead>
</table>

Cell Phone Number: ______________________________________

<table>
<thead>
<tr>
<th>DOB: _______ / _______ / _______ (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

E-mail: ___________________________@fordham.edu

<table>
<thead>
<tr>
<th>Graduating Year: ______________</th>
</tr>
</thead>
</table>

---

Please check off those that apply:

- International Student (F-1, J-1)
- Domestic Student

<table>
<thead>
<tr>
<th>Campus: ___ Rose Hill ___ Lincoln Center ___ Westchester</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Status: ___ Undergraduate ___ Graduate (incl. GBA) ___ Law Student</th>
</tr>
</thead>
</table>

---

### SECTION I: MMR (Measles, Mumps, Rubella)

For ALL students born after 01/01/1957 – 2 Doses

- **MMR #1:**
  - ___ / ___ / ___ (on or after 1st birthday)
  - mo. day yr.

- **MMR #2:**
  - ___ / ___ / ___ (after 15 mo. of age or 28 days after 1st dose)
  - mo. day yr.

**OR:** Vaccination dates of 2 Measles, 2 Mumps, and 1 Rubella vaccinations

| Measles: ___ / ___ / ___ |
| Mumps: ___ / ___ / ___ |
| Rubella: ___ / ___ / ___ |
| mo. day yr. | mo. day yr. | mo. day yr. |

| Measles: ___ / ___ / ___ |
| Mumps: ___ / ___ / ___ |
| Rubella: ___ / ___ / ___ |
| mo. day yr. | mo. day yr. | mo. day yr. |

**OR:** Blood Antibody Titer Test (Serological Proof of Immunity)

| Measles: ___ / ___ / ___ |
| Mumps: ___ / ___ / ___ |
| Rubella: ___ / ___ / ___ |
| mo. day yr. | mo. day yr. | mo. day yr. |

**History of Disease:** Any history of contracting the Measles, Mumps or Rubella disease, please indicate date(s) below.

| Measles: ___ / ___ / ___ |
| Mumps: ___ / ___ / ___ |
| Rubella: ___ / ___ / ___ |
| mo. day yr. | mo. day yr. | mo. day yr. |

---

### SECTION II: MENINGITIS VACCINE or MENINGITIS WAIVER

(option to sign below)

#### Required Meningitis Vaccine(s): Menomune or Menactra (or must sign Meningitis Waiver below)

| Menomune: ___ / ___ / ___ |
| Menactra: ___ / ___ / ___ |
| mo. day yr. | mo. day yr. |

#### Recommended After Age 18: To protect against Meningococcal Meningitis)

- Meningococcal B (Trumenba) Dose 1: ___ / ___ / ___
  - Dose 2: ___ / ___ / ___
  - Dose 3: ___ / ___ / ___
  - mo. day yr. | mo. day yr. | mo. day yr. |

- Meningococcal B (Bexero) Dose 1: ___ / ___ / ___
  - Dose 2: ___ / ___ / ___
  - mo. day yr. | mo. day yr. | mo. day yr. |

#### Meningitis Waiver: Mandatory waiver must be signed if student did not receive required meningitis vaccines

I have, or for students under 18, “My child has”:

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: ____________________________

---
SECTION III: TUBERCULOSIS (TB) RISK FACTOR SCREENING

Tuberculin Skin Test (Mantoux/Intermediate PPD) must be read by a healthcare provider 48-72 hours after administration. If there is no induration, indicate “0” under ‘Reading.’ Tine or Mono-Vac tests are not acceptable.

For Part A below, please provide either Mantoux (TST) or IGRA (Interferon Gamma Release Array).

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Positive Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close contact with case of TB or is immunocompromised</td>
<td>5 mm or more</td>
</tr>
<tr>
<td>Born in country with high rate of TB</td>
<td>10 mm or more</td>
</tr>
<tr>
<td>Traveled or lived for &gt; or = 1 month in a country with a high rate of TB</td>
<td>10 mm or more</td>
</tr>
<tr>
<td>No risk factors (TST should not be performed)</td>
<td>15 mm or more</td>
</tr>
</tbody>
</table>

A. TST (Mantoux): Tuberculosis Skin Test

Date Placed: ____/____/____  Date Read: ____/____/____  Reading: ___________ (in mm.)

IGRA: Tuberculosis Blood Test

Date: ____/____/____

TST or IGRA Test Result: Please check ONE.

[ ] Negative  [ ] Positive

If POSITIVE test, please complete Part B below.

B. If Tuberculin Skin Test or IGRA is positive, now or previously, the following are required:

1. Date of Positive TST or IGRA: Date: ____/____/____

2. Chest X-ray: (please attach copy of report) Date: ____/____/____

   Check off:

   Normal  [ ]

   Abnormal  [ ]

   Describe: _____________________________________________________________

3. Clinical Evaluation:

   Describe: _____________________________________________________________

4. Treatment (please circle): YES or NO

   Please explain: _________________________________________________________

   Drug, Dose, Frequency (include dates): __________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

B. Tuberculin Skin Test or IGRA is positive, now or previously, the following are required:

   Date: ____/____/____

   Check off:

   Normal  [ ]

   Abnormal  [ ]

   Describe: _____________________________________________________________

3. Clinical Evaluation:

   Describe: _____________________________________________________________

4. Treatment (please circle): YES or NO

   Please explain: _________________________________________________________

   Drug, Dose, Frequency (include dates): __________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

C. WAIVER (OPTION): Tuberculin Skin Test or IGRA Screening NOT indicated

ONLY to be completed by healthcare provider if he/she can confirm that individual has none of the risk factors listed on Page 2.

Healthcare Provider Signature (required): ________________________________  Date: ______________

Phone Number: __________________ Fax Number: __________________________
Name: ___________________________  DOB: _____________  FIDN: A___________________

SECTION IV: RECOMMENDED (NOT MANDATORY)

A. Tetanus-Diphtheria (Immunication booster within last 10 years):

   Date:   ____/____/____
           mo.  day  yr.

B. Hepatitis B Vaccine

   Dose 1:   ____/____/____
             mo.  day  yr.
   Dose 2:   ____/____/____
             mo.  day  yr.
   Dose 3:   ____/____/____
             mo.  day  yr.

C. Hepatitis A Vaccine

   Dose 1:   ____/____/____
             mo.  day  yr.
   Dose 2:   ____/____/____
             mo.  day  yr.

An official stamp of a doctor’s office, clinic, or health department AND and authorized signature must be provided below.

Name/License # (Office Stamp)  Clinician Signature  Date

Mail/Fax/E-mail Scanned Document

Fordham University Health Services
Attn: Immunizations
441 East Fordham Road, Bronx, NY 10458
Phone: 718-817-4160  Fax: 718-817-3218
E-mail: health@fordham.edu