FORDHAM UNIVERSITY HEALTH SERVICES
2017-2018

Please follow these directions:

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 PHL 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 (Rubeola): 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 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 one dose 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 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 given no more than 4 days prior to the student's first birthday; or
   - The student must submit serological proof of immunity to rubella. This means the demonstration of rubella antibodies through a blood test performed by an approved medical laboratory (Since rubella rashes resemble rashes of other diseases, it is impossible
to diagnose reliably on clinical grounds alone. Serological evidence is the only permissible alternative to immunization.); 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.

Section II. Tuberculosis (TB) Risk Factor Screening:

**EITHER ITEM A OR B MUST BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER.**

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

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 years old receive the Hepatitis A vaccine.

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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
FORDHAM UNIVERSITY HEALTH SERVICES
2017-2018

Name: ___________________________________________          Fordham ID #: A ____________________________

Cell Phone Number: _______________________________          DOB: ______/______/______ (MM/DD/YYYY)

E-mail: ____________________@fordham.edu            Graduating Year: ______________

Please check off those that apply:

___ International Student (F-1, J-1)          Campus: ___ Rose Hill          ___ Lincoln Center          ___Westchester

___ Domestic Student          Status: ___ Undergraduate          ___ Graduate (incl. GBA)          ___ Law Student

SECTION I: MMR (Measles, Mumps, Rubella: For ALL students born after 01/01/1957)

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 #1: ___ / ___ / ___          Mumps #1: ___ / ___ / ___          Rubella: ___ / ___ / ___

mo. day yr.          mo. day yr.          mo. day yr.

Measles #2: ___ / ___ / ___          Mumps #2: ___ / ___ / ___

mo. day yr.          mo. day yr.

OR: Blood Antibody Titer Test (Immunity)

Measles: ___ / ___ / ___          Mumps: ___ / ___ / ___          Rubella: ___ / ___ / ___

mo. day yr.          mo. day yr.          mo. day yr.

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

Measles: ___ / ___ / ___          Mumps: ___ / ___ / ___

mo. day yr.          mo. day yr.

SECTION II: MENINGITIS or WAIVER

Meningococcal Meningitis Vaccine (Menomune, Menactra A, C, W-135, Y): Please provide at least one.

Menomune: ___ / ___ / ___          ___ / ___ / ___

mo. day yr.          mo. day yr.

Menactra: ___ / ___ / ___          ___ / ___ / ___

mo. day yr.          mo. day yr.

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.

WAIVER: Optional

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: _________________________

(Parent or guardian if under 18)
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 (if TST done)</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: _____/_____/_____  

   Check off:  
   Normal [ ]  
   Abnormal [ ]  
   Describe: ____________________________________________

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

   Describe: ____________________________________________

3. Clinical Evaluation: Describe: ____________________________________________

4. Treatment (please circle): YES or NO  

   Please explain: ____________________________________________

   Drug, Dose, Frequency (include dates): ____________________________________________

Name/License # (Office Stamp) Clinician Signature Date

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: __________________________
SECTION IV: RECOMMENDED (NOT MANDATORY)

A. Tetanus-Diptheria (*immunization 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 an 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