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, II, & III ARE MANDATORY

SECTION IV IS ONLY RECOMMENDED (encouraged if student has a medical condition or is on prescribed medication(s))
- 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. 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,
- 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 contracting 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.ny.gov/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

International students from high risk countries must have IGRA testing. 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 South 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.
FORDHAM UNIVERSITY HEALTH SERVICES
2018-2019

Name: ________________________________

Cell Phone Number: ____________________

E-mail: ________________________________

Fordham ID #: A________________________

DOB: _______/________/_________ (MM/DD/YYYY)

E-mail: ________________________________

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) – 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 #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 (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: ____ / ____ /____

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.

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).

### TST Interpretation Guidelines

<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.)

mo.     day       yr.                                                  mo.     day       yr.

IGRA: Tuberculosis Blood Test (MANDATORY for International Students)

Date: ____/____/____

mo.      day      yr.

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: _____/____/____

   mo.     day       yr.

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

   mo.     day       yr.

   Check off:
   
   Normal [ ]

   Abnormal [ ]

   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-Diphtheria (Immunization booster within last 10 years):
   Date: _____ / _____ / _____
       Mo.   day   yr

B. Hepatitis B Vaccine

   Date: _____ / _____ / _____
       Mo.   day   yr

C. Hepatitis A Vaccine

   Date: _____ / _____ / _____
       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: 718-817-0940   Fax: 718-817-3218
Email: health@fordham.edu