

New York University School of Medicine Student Health Service  
MEDICAL STUDENT IMMUNIZATION RECORD

545 First Avenue, C122, New York, NY 10016 tel. (212)-263-5489 Fax: (212)263-3280  
www.med.nyu.edu/studenthealth

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

**The following vaccines are required for all students (number 1 through 5)**

1. MMR #1 Date: \_\_\_\_\_ MMR #2 Date: \_\_\_\_\_  
(Measles/Mumps/Rubella)

OR

a. Rubeola Vaccine (Measles) #1 Date: \_\_\_\_\_ #2 Date: \_\_\_\_\_

b. Mumps Vaccine Date: \_\_\_\_\_

c. Rubella Vaccine (German Measles) Date: \_\_\_\_\_

2. Tetanus Toxoid or Diphtheria-Tetanus Toxoid Dates of primary series: \_\_\_\_\_

Date of last Booster (within the last 10 years) \_\_\_\_\_ (circle one): Adacel or Td

3. Meningococcal Vaccine Date: \_\_\_\_\_ (circle one): Menactra or Menomune  
(within the last 3 years)

4. Hepatitis B Vaccine Date: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

5. Polio (primary series) Dates: \_\_\_\_\_ (booster) Date: \_\_\_\_\_

**Please provide the dates if you have received the following vaccinations: (not required)**

Hepatitis A Vaccine Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_

Varicella Vaccine Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_

Typhoid vaccine Date: \_\_\_\_\_ (circle one) oral or injection

Yellow Fever Vaccine Date: \_\_\_\_\_

BCG Vaccine Date: \_\_\_\_\_

Tuberculin Test (Mantoux)\* Date planted: \_\_\_\_\_ Date read: \_\_\_\_\_

Results: \_\_\_\_\_ mm Positive [ ] Negative [ ]

\*If positive, results and date of last chest x-ray and treatment:  
(Please attach a copy of the chest x-ray report)

Signature of Health Care Provider: \_\_\_\_\_

Print Name, State & License # \_\_\_\_\_

Office address \_\_\_\_\_

Telephone \_\_\_\_\_

Return all forms to Student Health Service at the above address or fax