COLGATE UNIVERSITY
Hamilton, NY 13346-1398

IMMUNIZATION RECORD

Immunity is required prior to registration. Please complete and return this form.

Student Health Service
315/228-7750

PART I — TO BE COMPLETED BY STUDENT (Please Print)

Name ____
Last First M.I.

Date of Birth (Month / Day / Year) ____/____/____ Colgate Class Year __________

New York State Public Health Law requires that all students born after December 31, 1956 be adequately immunized. ***You are legally required to provide this information and to get the necessary immunizations, or you will be DENIED enrollment.*** If you qualify for a medical or religious exemption, please **complete Part IV**.

Part II - Meningococcal Vaccine

As required by NYS Public Health Law, I have read or had explained to me, the information enclosed with this form about meningococcal disease.
After choosing one of the following, the student or parent/guardian (if student under age 18) **must sign below.***

A. ____ I have had the Quadrivalent Meningococcal Conjugate Vaccine: Dose #1 Date: ___/___/___ AND *(If more than 5 years since Dose #1)* Dose #2 Date: ___/___/___

OR

____ I decline to receive the vaccine at this time and understand the risks.

***Student or Parent/Guardian (if student under age 18) Signature**__________________________________ **Date**______________

B. ____ Meningococcal B Vaccine – discuss with your primary care provider. **Please indicate type and dates if received**.
Please Circle Brand Name: **Bexsero OR Trumenba** Dose #1 Date: ___/___/___ Dose #2 Date: ___/___/___ (If Applicable) Dose #3 Date: ___/___/___

PART III — TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR.

If convenient, you may attach a ***signed*** copy of your immunization records, which must include all previous and recent shots.

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)
1. Dose 1 given at age 12-15 months or later. [ ]

AND

2. Dose 2 given at age 4-6 years or later, and at least one month after first dose. [ ]

B. Tetanus-Diphtheria-Pertussis (Primary series with DtaP or DTP and booster in the last ten years meets requirement.)
1. Primary series of at least four doses with DtaP or DTP: #1 [ ] #2 [ ] #3 [ ] #4 [ ] #5 [ ]

AND

2. Tetanus-Diphtheria-Acellular Pertussis (Tdap) booster (one dose as an adult) [ ]
3. Please indicate date and type of any other tetanus vaccine: Type: ____________________ Date: ___/___/___

C. Polio (Primary series in childhood meets requirement.) #1 [ ] #2 [ ] #3 [ ] #4 [ ]

D. Varicella (Either a history of **chicken pox**, a positive Varicella antibody, or two doses of vaccine given at least one month apart, meets the requirement.)
1. History of Disease: No _____ **OR** Yes _____ (include date) [ ]

OR

2. Varicella antibody: Non-reactive _____ **OR** Reactive _____ (include date) [ ]

OR

3. Immunization: #1 [ ] #2 (given at least one month after first dose) [ ]

E. Hepatitis B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)
1. Immunization: #1 [ ] #2 [ ] #3 [ ]

OR

2. Hepatitis B surface antibody: Non-reactive _____ **OR** Reactive _____ (include date) [ ]

F. Quadrivalent Human Papillomavirus Vaccine State month, day and year.
1. HPV-4 #1 [ ] #2 [ ] #3 [ ]

OR

2. HPV-9 #1 [ ] #2 [ ] #3 [ ]

G. Hepatitis A (Two doses, given at least 6 months apart, for those who travel to parts of the USA or other countries with high rates of Hepatitis A.)
State month, day and year. #1 [ ] #2 [ ]

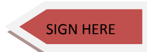
H. Other Other Immunizations (such as Pneumococcal, etc.): ____

I. Tuberculosis Screening -- SEE SEPARATE FORM

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Name (please print): ______________________________________

Signature: ______________________________________ **Title:** ____________________ **Date:** ______________



Address: ______________________________________ **Phone:** ____________________ **Fax:** ______________

PART IV - STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS WILL BE SUBJECT TO EXCLUSION FROM SCHOOL AND QUARANTINE.

MEDICAL EXEMPTION

The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

______________________________________ ______________
Signature of Physician Date

RELIGIOUS EXEMPTION

Parent or guardian of the above named person or the person himself/herself adheres to a religious belief opposed to immunizations.

______________________________________ ______________
Student's Signature (parent/guardian if under 18) Date