NEW YORK UNIVERSITY
A private university in the public service

Student MMR Immunization Form
REQUIRED

RETURN FORM TO:
NYU Student Health Center • Immunization Record Services • 726 Broadway, Suite 336 • New York, NY 10003 • Tel: (212) 443-1199 • Fax: (212) 443-1198

Name: _____ **School:** _____

Date of Birth: _____/_____/_____ **University I.D. Number:** N - _____

*** Persons born before January 1, 1957 are exempt from this requirement and do not need to submit this form.**

TO BE IN COMPLIANCE, YOU MUST HAVE BOTH ITEMS IN SECTION A...

Month / Day / Year

A. M.M.R. (Measles, Mumps, Rubella) If given instead of individual immunization.

1st Dose: Immunized on or after first birthday, AND on or after January 1, 1972 _____/_____/_____

2nd Dose: Immunized 15 months after birth or later, AND at least 28 days after first dose _____/_____/_____

OR ONE EACH OF THE FOLLOWING: B, C, AND D.
Check appropriate items and enter dates.

B. MEASLES (Rubeola)

1.____ Had the disease, confirmed by office record _____/_____/_____

2.____ Has report of adequate immune titer - MUST SUBMIT COPY OF LAB REPORT _____/_____/_____

3.____ Dose 1: Immunized on or after first birthday AND on or after January 1, 1968 _____/_____/_____

AND

Dose 2: Immunized 15 months after birth or later AND at least 28 days after first dose _____/_____/_____

C. MUMPS

1.____ Had the disease, confirmed by office record _____/_____/_____

2.____ Has report of adequate immune titer - MUST SUBMIT COPY OF LAB REPORT _____/_____/_____

3.____ Dose 1 Immunized on or after first birthday AND on or after January 1, 1969 _____/_____/_____

AND

Dose 2: Immunized at least 28 days after first dose _____/_____/_____

D. RUBELLA (German Measles)

1.____ Has report of adequate immune titer - MUST SUBMIT COPY OF LAB REPORT _____/_____/_____

2.____ Dose 1 Immunized on or after first birthday AND on or after January 1, 1969 _____/_____/_____

AND

Dose 2: Immunized at least 28 days after first dose _____/_____/_____

NOTE: PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

PLEASE NOTE: This form will not be accepted if this section is not completed in its entirety.

Healthcare Provider Name (MD, NP, RN):_____

Signature: _____ Date: _____

Healthcare Provider Stamp or Office Stamp for Address: _____

Telephone: _____ Lic #: _____