CornellHealth

Immunization and TB Screening History FORM

Student name *(last, first, middle)* _____

Date of birth *(mm-dd-yy)* _____ **Cornell student ID #** _____

INSTRUCTIONS

Step 1: Ask your health care provider to complete this form, or obtain comparable official records from your health care provider, school, or military.
Step 2: Go to myCornellHealth, and open the New Student Immunization and TB Screening History form.
Step 3: Enter your immunization information (and, if required, TB screening test results).
Step 4: Upload a copy of this form or other comparable official records.

REQUIRED IMMUNIZATIONS

Students taking 6 or more credits must provide documentation that you have met all of these immunization requirements (items 1–4).

1. Measles/Mumps/Rubella. Complete Option 1 or Option 2.

Option 1: Option 1: Two doses of live MMR **on or after the first birthday** (Must have been given at least 28 days apart.)
Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____

OR

Option 2: If vaccines were given separately, select one in each disease category (below).

Measles. Check one box only.

☐ Two doses of live vaccine administered **on or after the first birthday** (Must have been given at least 28 days apart.)
Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____
☐ Physician-diagnosed illness Date *(mm-dd-yy)* _____
☐ Protective antibody titer Date *(mm-dd-yy)* _____ Lab ☐ positive ☐ negative If negative, student must receive vaccine.

Mumps. Check one box only.

☐ Two doses of live vaccine administered **on or after the first birthday**
Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____
☐ Physician-diagnosed illness Date *(mm-dd-yy)* _____
☐ Protective antibody titer Date *(mm-dd-yy)* _____ Result: ☐ positive ☐ negative If negative, student must receive vaccine.

Rubella. Check one box only. (Previous clinical diagnosis of rubella is not sufficient.)

☐ One dose of live vaccine administered on or after the first birthday
Date *(mm-dd-yy)* _____
☐ Protective antibody titer Date *(mm-dd-yy)* _____ Result: ☐ positive ☐ negative If negative, student must receive vaccine.

2. Meningococcal Vaccine. Check all that apply.

A booster shot is required of the starred (*) vaccines if your original vaccine was not received within the past 5 years.

☐ Menactra™ * Original date (mm-dd-yy)_____ Booster* *(mm-dd-yy)* _____
☐ Menveo™ * Original date (mm-dd-yy)_____ Booster* *(mm-dd-yy)* _____
☐ Menomune™ * Original date (mm-dd-yy)_____ Booster* *(mm-dd-yy)* _____
☐ Meningococcal ACYW-135 * Specify other brand or brand unknown _____
Original date (mm-dd-yy)_____ Booster* *(mm-dd-yy)* _____

☐ Trumenba™ *(for Type B only)* Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____ Date #3 *(mm-dd-yy)* _____
☐ Bexsero™*(for Type B only)* Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____

☐ I have 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 the meningococcal vaccine. I understand I must sign and upload Cornell Health's meningococcal waiver form. [This form is available on the New Student Immunizations and TB History form (item #16) accessed through myCornellHealth.]

3. Tetanus/diphtheria/pertussis booster (Tdap) Date *(mm-dd-yy)* _____ You must have received a Tdap vaccine in the past 10 years.

4. Varicella (Chicken Pox). Check all that apply.

If you were born in the U.S. before 1980, this requirement does not apply.

☐ Two doses of vaccine Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____
☐ Physician-diagnosed illness Date *(mm-dd-yy)* _____
☐ Protective antibody titer Date *(mm-dd-yy)* _____ Result: ☐ positive ☐ negative If negative, student must receive vaccine.

RECOMMENDED IMMUNIZATIONS

These immunizations are recommended by the U.S. Centers for Disease Control and Prevention (CDC) and the American College Health Association. To protect your health, we urge students to receive these important vaccinations *(or begin the series)* before starting at Cornell. Please provide dates.

Hepatitis A Vaccine

Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____

Hepatitis B Vaccine

Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____ Date #3 *(mm-dd-yy)* _____

HEP A / HEP B Combined Vaccine

Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____ Date #3 *(mm-dd-yy)* _____

Human Papillomavirus (HPV) Vaccine Series *(recommended for students of all genders, 26 and under)*

Date #1 *(mm-dd-yy)* _____ Date #2 *(mm-dd-yy)* _____ Date #3 *(mm-dd-yy)* _____

OTHER VACCINATIONS YOU MAY HAVE RECEIVED

HIB Vaccine (Haemophilus Influenza B) Date *(mm-dd-yy)* _____

Pneumococcal Vaccine Date *(mm-dd-yy)* _____

Polio Vaccine (before age 18) Check one box only.

☐ IPOL Date of most recent dose *(mm-dd-yy)* _____

☐ OPV Date of most recent dose *(mm-dd-yy)* _____

☐ EPV DOSE #1 *(mm-dd-yy)* _____ DOSE #2 *(mm-dd-yy)* _____ DOSE #3 *(mm-dd-yy)* _____

Rabies Vaccine

Date #1 *(mm-dd-yy)* _____ ☐ RabAvert ☐ Imovax ☐ Unknown

Date #2 *(mm-dd-yy)* _____ ☐ RabAvert ☐ Imovax ☐ Unknown

Date #3 *(mm-dd-yy)* _____ ☐ RabAvert ☐ Imovax ☐ Unknown

Typhoid Vaccine Date *(mm-dd-yy)* _____

Yellow Fever Vaccine Date *(mm-dd-yy)* _____

TUBERCULIN (TB) SCREENING TEST

- REQUIRED for students from countries with a high incidence of TB: you must have a blood test (T-SPOT or Quantiferon-TB Gold). Students with a positive TB test result must have a chest x-ray. If you are unable to get your required test before arriving at Cornell, you will have to get it as soon as you arrive.
- Recommended for all students, especially those who have spent time in countries with a high incidence of TB.
- Review list of countries with a high incidence of TB on the New Student Immunization and TB Screening History form at myCornellHealth.

Check all Tuberculin screening tests you have had.

☐ PPD, Mantoux (skin tests) Date *(mm-dd-yy)* _____ Result: _____ mm of induration

☐ T-SPOT®.TB (blood test) Date *(mm-dd-yy)* _____ Result: ☐ positive ☐ negative

☐ QuantiFERON®-TB Gold (blood test) Date *(mm-dd-yy)* _____ Result: ☐ positive ☐ negative

☐ Chest x-ray Date *(mm-dd-yy)* _____ Result: ☐ normal ☐ abnormal

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE

Signature _____ Date *(mm-dd-yy)* _____

Name _____ Work Phone _____

last, first, middle *degree/title*

Address _____