2023-24 IMMUNIZATIONS:
Medical Provider Documentation

INSTRUCTIONS

Step 1: Ask your health care provider to complete and sign this form. NOTE: If you have comparable official records from your health care provider, school, or military, you may submit those rather than using this form.

Step 2: Once you have your records, go to myCornellHealth, and select the Medical Clearance section from the menu.

Step 3: Enter your immunization information on your Medical Clearance list.

Step 4: Select “Upload Immun. Records” to provide a copy of this form OR other comparable official records.

Student name (last, first, middle) _______________________________________________________________

Date of birth (mm-dd-yy) ____________________________ Cornell Net ID # ____________________________

REQUIRED IMMUNIZATIONS

Students taking 6 or more credits must provide this completed form signed by your health care provider or comparable official records that indicate the dates you received the following immunizations.

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

Option 1: Two doses of live MMR 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) ____________________________

Option 2: If vaccines were given separately, select one each for Measles, Mumps, and Rubella.

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) ____________________________

☐ Protective antibody titer

Date (mm-dd-yy) ____________________________ Result: ☐ positive ☐ negative

☐ Physician-diagnosed illness

Date (mm-dd-yy) ____________________________ Lab ☐ positive ☐ negative

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) ____________________________

☐ Protective antibody titer

Date (mm-dd-yy) ____________________________ Result: ☐ positive ☐ negative

☐ Physician-diagnosed illness

Date (mm-dd-yy) ____________________________

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

2. Meningococcal. Complete Option 1, 2, or 3.

Option 1: Meningococcal conjugate vaccine (including Menactra™, Menveo™, Menomune™, Meningococcal ACYW-135, or other). The date of your conjugate vaccine should be within the past 5 years.

☐ Meningococcal type/brand (if known) ____________________________ Date (mm-dd-yy) ____________________________

Option 2: Meningococcal Type B.

☐ Trumeba™ Date #1 (mm-dd-yy) ____________________________ Date #2 (mm-dd-yy) ____________________________ Date #3 (mm-dd-yy) ____________________________

☐ Bexsero™ Date #1 (mm-dd-yy) ____________________________ Date #2 (mm-dd-yy) ____________________________

Option 3: Meningococcal waiver.

☐ I have decided not to obtain the meningococcal vaccine. I understand I must submit a waiver documenting my decision.

(Log in to myCornellHealth, go to the Downloadable Forms tab, then download, complete, and upload the Meningococcal Vaccine Waiver Form.)

3. Pertussis (Tdap).

☐ Tdap administered age 10 or later Date (mm-dd-yy) ____________________________
4. Tetanus.

If your Tdap vaccine was more than 10 years ago, you must enter a more recent tetanus booster. Check one box only. Date must be within the past 10 years.

☐ Td-adult        Date (mm-dd-yy) ________________________________
☐ Tetanus toxoid  Date (mm-dd-yy) ________________________________

5. 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 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) ________________________________
  ______________   ______________
  Protective antibody titer:
  Date (mm-dd-yy) ________________________________ Result: ☐ positive ☐ negative
  ________________________________
  Physician-diagnosed illness:
  Date (mm-dd-yy) ________________________________
  ________________________________

RECOMMENDED IMMUNIZATIONS

If you have had any of the vaccines below, please provide the dates and have your health care provider sign this form.

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 IMMUNIZATIONS

If you have had any of the vaccines below, please provide the dates and have your health care provider sign this form.

COVID-19 Vaccine.

  Type/brand ________________________________ Date #1 (mm-dd-yy) ________________________________ Date #2 (mm-dd-yy) ________________________________

HIB Vaccine (Haemophilus Influenza B).
  Date (mm-dd-yy) ________________________________

Pneumococcal Vaccine.
  Date (mm-dd-yy) ________________________________

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

☐ IPV 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) ________________________________

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE

Signature ________________________________ Date (mm-dd-yy) ________________________________

Name ________________________________ Work Phone ________________________________

last, first, middle degree/title

Address ________________________________