CornellHealth

2024-25 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)* _____ Lab ☐ positive ☐ negative

☐ Physician-diagnosed illness Date *(mm-dd-yy)* _____

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.**

☐ Trumenba™ 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.

☐ Tdap Date *(mm-dd-yy)* _____
☐ 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.
☐ 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)* _____

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE

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

Name _____ Work Phone _____
last, first, middle *degree/title*

Address _____