THE COLLEGE OF NEW ROCHELLE

HEALTH FORM

THIS FORM MUST BE COMPLETED AND RETURNED TO COUNSELING & HEALTH SERVICES OFFICE PRIOR TO CLASS REGISTRATION BY ALL STUDENTS

Name: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip)

Circle One: SNHP SAS SNR GS

E-mail Address: _____ Phone: _____

Campus: _____

It is the responsibility of the student to notify The Counseling & Health Services Office of any chronic or recurrent physical or psychological health condition that may impede their college success.

Signature: _____ Date: _____
Student (over 18) or Parent/Guardian (for minors)

NEW YORK STATE PUBLIC HEALTH LAW, SECTION 2165, REQUIRES ANY STUDENT BORN ON OR AFTER JANUARY 1, 1957, WHO IS REGISTERED TO ATTEND CLASSES AT A POST-SECONDARY INSTITUTION, WHETHER FULL-TIME OR PART-TIME, MUST SUBMIT THEIR MMR (MEASLES, MUMPS, RUBELLA) VACCINE INFORMATION.

MMR (Measles, Mumps, Rubella – Combines) Vaccine ___/___/___ ___/___/___
(mm/dd/yy) (mm/dd/yy)

OR

Measles (Rubeola) Immunity: Check & complete all that apply:

- ☐ Two doses of live measles vaccine ___/___/___ ___/___/___
(mm/dd/yy) (mm/dd/yy)

OR

- ☐ Date of immune measles titer ___/___/___
(mm/dd/yy)

Mumps Immunity: Check & complete all that apply:

- ☐ One dose of mumps vaccine ___/___/___/ ___/___/___
(mm/dd/yy) mm/dd/yy)

OR

- ☐ Date of immune mumps titer ___/___/___
(mm/dd/yy)

Rubella (German Measles) Immunity: Check & complete all that apply:

- ☐ One dose of rubella vaccine ___/___/___/ ___/___/___
(mm/dd/yy) (mm/dd/yy)

OR

- ☐ Date of immune rubella titer ___/___/___ ___/___/___
(mm/dd/yy) (mm/dd/yy)

Health Care Provider Signature License Number Date

MENINGITIS – THIS NOTICE IS REQUIRED BY PUBLIC HEALTH LAW SECTION 2167
New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester respond to the following information.
Check one box and sign below.

I have . . . .

□ Had the meningococcal immunization within the past 5 years. The vaccine record is attached.

(Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that, young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College students should discuss the Meningococcal B vaccine with a healthcare provider).

□ Read, or have explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease **within 30 days** from my private healthcare provider.

□ 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 immunization against meningococcal meningitis disease.

Signature: _____ Date: _____
(Student or Parent/Guardian)

***** PLEASE ATTACH A COPY OF BOTH SIDES OF INSURANCE CARD TO THIS FORM *****

STRONGLY RECOMMENDED;
PLEASE ATTACH A COPY OF YOUR IMMUNIZATION RECORD:

_____ PPD RESULT _____		_____/_____/_____
_____TDaP or TD (within 10 years)		_____/_____/_____
_____ Hepatitis B Series	#1	_____/_____/_____
	#2	_____/_____/_____
	#3	_____/_____/_____
_____ HPV	#1	_____/_____/_____
	#2	_____/_____/_____
	#3	_____/_____/_____