

### 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) \_\_\_\_\_

