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.

Student name (last, first, middle)				
Date of birth (mm-dd-yy)		et ID#		
REQUIRED IMMUNIZATION	NS			
Students taking 6 or more credits received the following immunization	must provide this completed form signed by ons.	your health care provider o	comparable official red	cords that indicate the dates you
1. Measles/Mumps/Rubella. Com	plete Option 1 or Option 2.			
Option 1: Two doses of live MM	IR administered on or after the first birthday (mu Date #1 (<i>mm-dd-yy</i>)	•		
Option 2: If vaccines were giver	n separately, select one each for Measles, Mumps,	and Rubella.		
Measles. Check one box only. ☐ Two doses of live vaccine ac	dministered on or after the first birthday (must ha			
☐ Protective antibody titer	Date #1 (mm-dd-yy) Date (mm-dd-yy)	_	□ negative	
☐ Physician-diagnosed illness	Date (mm-dd-yy)		- negative	
Mumps. Check one box only. ☐ Two doses of live vaccine ac	dministered on or after the first birthday Date #1 (<i>mm-dd-yy</i>)	Date #2 (<i>mm-dd-yy</i>)		
☐ Protective antibody titer	Date (mm-dd-yy)		negative	
☐ Physician-diagnosed illness	Date (mm-dd-yy)			
_	evious clinical diagnosis of rubella is not sufficient ministered on or after the first birthday			
☐ Protective antibody titer	Date (mm-dd-yy) Date (mm-dd-yy)		☐ negative	
2. Meningococcal. Complete Optio				
-				
Option 1: Meningococcal conjugation within the past 5 years	ugate vaccine (including Menactra™, Menveo™, N rs.	Aenomune™, Meningococcal AC\	'W-135, or other). The date	e of your conjugate vaccine should be
☐ Meningococcal type/brand	(if known) Date (mm-c	(d-yy)		
Option 2: Meningococcal Type	В.			
□ 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 waiv	er.			
	n the meningococcal vaccine. I understand I must s go to the Downloadable Forms tab, then downloa	• ,		r Form.)
3. Pertussis (Tdap).				

4. Tetanus.					
If your Tdap vaccine was more than 1	0 years ago, you must enter a more	recent tetanus l	booster. Check one box	only. Date must be within the past 10 year	rs.
☐ Tdap	Date (mm-dd-yy)				
☐ Td-adult	Date (mm-dd-yy) Date (mm-dd-yy)				
☐ Tetanus toxoid	Date (mm-dd-yy)				
5. Varicella (Chicken Pox). Check all tha	t apply. If you were born in the U.S.	before 1980, this	s requirement does not a	apply.	
Two doses of vaccine administered on or after the first birthday (must have been given at least 28 days a Date #1 (mm-dd-yy)					
☐ Protective antibody titer:	Date (mm-dd-yy)				
Physician-diagnosed illness:	Date (mm-dd-yy)		·	•	
RECOMMENDED IMMUNIZAT	IONS If you have had any of th	e vaccines below	, please provide the date	es and have your health care provider sign	this form.
Those immunizations are recommende	ad by the U.S. Centers for Dises	oco Control and	A Broyantian (CDC) an	ed the American College Health Asses	iation. To protect your
These immunizations are recommended health, we urge students to receive the	•			-	lation. To protect your
Treatility we dige students to receive the	ese important vaccinations (or	begin the serie	so, before starting at	correm ricuse 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	· · · · · · · · · · · · · · · · · · ·				
Date #1 (mm-dd-yy)	Date #2 (mm	-dd-yy)		Date #3 (mm-dd-yy)	
OTHER INAMI INITATIONS					
OTHER IMMUNIZATIONS If yo	u nave had any of the vaccines bei	ow, piease provid	ie the dates and have yo	our health care provider sign this form.	
COVID-19 Vaccine.					
Type/brand	Date #1 (mm-dd-yy)		Date #2 (mm-dd-)	vy)	
HIB Vaccine (Haemophilus Influenza E	B). Date (mm-dd-yy)				
Pneumococcal Vaccine. Date (mm	n-dd-yy)				
Polio Vaccine (before age 18). Check or	ne box only.				
☐ IPOL Date of most recent dose	e (mm-dd-yy)				
	e (mm-dd-yy)				
DOSE #1 (mm-dd-yy)	DOSE #2	(mm-dd-yy)		DOSE #3 (mm-dd-yy)	
Dahias Vassina					
Rabies Vaccine.	☐ RabAvert	☐ Imovax	Unknown		
Date #1 (mm-dd-yy)		☐ Imovax	☐ Unknown		
Date #2 (mm-dd-yy) Date #3 (mm-dd-yy)		☐ Imovax	☐ Unknown		
Date #3 (IIIII-da-yy)	LI NabAvert	IIIIOVAX	L CHRIOWII		
Typhoid Vaccine. Date (mm	n-dd-yy)				
Weller Service Version					
Yellow Fever Vaccine. Date (mm	a-dd-yy)				
HEALTH CARE PROVIDER INFO	RMATION AND SIGNATI	JRE			
Signature				Date (mm-dd-yy)	
Name				Work Phone	
last, first, middle	degree	e/title			
Address					