CornellHealth

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 using forms 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 documentation that you have met all four of these immunization requirements.

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 If negative, student must receive vaccine.

☐ 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 If negative, student must receive vaccine.

☐ 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 If negative, student must receive vaccine.

2. Meningococcal (conjugate vaccine). Check all that apply. The date of your vaccine should be within the past 5 years.

☐ Menactra™ Date *(mm-dd-yy)* ____________________

☐ Menveo™ Date *(mm-dd-yy)* ____________________

☐ Menomune™ Date *(mm-dd-yy)* ____________________

☐ Meningococcal ACYW-135 Specify other brand or brand unknown ________________________________

Date *(mm-dd-yy)* ____________________

☐ I have decided not to obtain the meningococcal vaccine. I understand I must submit a waiver documenting my decision. (On your myCornell Health Medical Clearance list, choose "Meningococcal" to download and submit 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)* ____________________

☐ Tdap 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 If negative, student must receive vaccine.

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

RECOMMENDED IMMUNIZATIONS

Requested of full-time students on the Ithaca campus ONLY; enter in “Other Vaccinations” on your Medical Clearance list.

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

Requested of full-time students on the Ithaca campus ONLY; enter in “Other Vaccinations” on your Medical Clearance list.

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

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)* ____________________

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 ____