In order to maintain the health of all students, New York State public health law requires that students attending postsecondary institutions in the state submit proof of immunization against certain vaccine preventable diseases. YU students may demonstrate immunity by presenting proof of having received two vaccinations for Rubeola (Measles), two vaccinations for Mumps, and at least one vaccination for Rubella (German Measles) or if given in combination, two M-M-R (Measles, Mumps and Rubella) vaccines. Immunity may also be affirmed by providing the results of a laboratory test (immune titer) for each disease and a copy of the report.

**MANDATORY IMMUNIZATIONS**

**Two Measles Mumps and Rubella (MMR) vaccinations**
- Date 1: Immunization no more than 4 days prior to student’s first birthday
- Date 2: Immunization at least 28 days after 1st vaccination
- Date of Birth
- If born before 1957, indicate birth date

**or**

**Two Measles (Rubeola) vaccinations**
- Date 1: Immunization no more than 4 days prior to student’s first birthday
- Date 2: Immunization at least 28 days after 1st vaccination
- Date of positive immune titer (attach lab report)

**Rubella (German Measles) vaccination**
- Date 1: Immunization with rubella vaccine, no more than 4 days prior to student’s first birthday, and after January 1, 1957
- Date of positive immune titer (attach lab report)

**Two Mumps vaccinations**
- Date 1: Immunization on or after first birthday and after January 1, 1957
- Date of positive immune titer (attach lab report)

**Physician Name (Office Stamp Required)**

Note: While meningitis vaccination is recommended by the NYS Department of Health but is not mandatory, a completed Meningitis Vaccination Response form (see below) must be submitted by every student.

**MENINGOCCAL MENINGITIS VACCINATION RESPONSE FORM**

New York State Public Health Law requires that all college and university students enrolled for at least six semester hours or the equivalent per semester, or at least four semester hours per quarter, must complete and return this form.

**COMPLETE THE INFORMATION SECTION BELOW; CHECK ONE RESPONSE BOX; SIGN AND DATE**

I have:
- ☐ had the Meningococcal Meningitis immunization (Menomune™ or Menactra™) within the past 10 years.
  - Date received
  - I will obtain immunization against Meningococcal Meningitis within 30 days from my private health care provider.
  - I understand the risks of not receiving the vaccine. I have decided I will **not** obtain immunization against Meningococcal Meningitis.

Signature _____________________________ Date _______________________

Student (if 18 years or older), otherwise parent