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Division of Higher Learning
Associated Beth Rivkah Schools

310 Crown Street
Brooklyn, New York 11225
(718) 735-0400 DHLSeminary@Bethrivkah.edu

IMMUNIZATION REQUIREMENT FOR STUDENTS
ATTENDING A NEW YORK STATE SCHOOL OF HIGHER EDUCATION

In accordance with New York State Public Health Laws, every student attending an institution of higher learning must submit the Meningitis Response Form and proof of immunity against measles, mumps and rubella prior to registering for classes.

PLEASE NOTE THAT THE NYS BOARD OF HEALTH MAY ISSUE A $2,000.00 FINE FOR EACH STUDENT WHO DOES NOT HAVE A RECORD OF IMMUNIZATIONS ON FILE!

Enclosed please find the Associated Beth Rivkah, DHL Student Immunization Record Form. Please fill it out as follows:

PART I MENINGITIS RESPONSE FORM refers to the **meningococcal meningitis immunization (menomune or menectra).**
If the student is under 18 years old, the parent must fill this out and sign it.
If the student is 18 years old or older, the student must fill it out and sign it.

PART II refers to the **measles, mumps and rubella immunity,** either with the immunizations, history of illness (this does not apply to rubella), or through immunization proven through serologic (blood) testing.

If the student is in the process of completing the requirements of these immunizations, she needs a certificate of immunization proving that she has received at least one dose each of the live measles, mumps and rubella virus vaccines and has an appointment to return to the health practitioner for the 2nd dose of the live measles virus vaccine within 90 days of the first measles vaccine.

Your cooperation in this matter is much appreciated.

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STUDENT IMMUNIZATION RECORD FORM

Name:_____ Date of Birth:___/____/____ Last 4 digits Social Security # _ _ _ _

Home Address_____

Home Phone #:_____ Student's Cell Phone# _____:_____

Student's E-mail _____Parent's Email _____

Part I – MENINGITIS RESPONSE FORM - to be checked, completed and signed by the student (or parent if student is under age 18)

____I have had the meningococcal meningitis immunization (Menomune) within the past 10 years Date_____

____I will obtain immunization against meningococcal meningitis **within 30 days** from my private health provider.

____ I have 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 will **not** obtain immunization against meningococcal meningitis disease.

Student / Parent Signature:_____ Date_____

Part II – **Vaccination record to be completed and signed by a licensed health care provider.**

	MEASLES	MUMPS	RUBELLA	COMBINED MMR
Vaccination dates (Two doses required for measles or MMR)	Dose 1:			Dose 1:
	Dose 2:			Dose 2:
Scheduled date for Dose 2 of measles or MMR				
Disease History (date of onset)				
Serology date and result (Include copy of lab report)				

I certify that the above information is correct.

Health Care Provider Signature_____

Printed Name and Title _____Phone_____

Address_____Date_____