

Immunization Report/ Part II
Student Health Center Clarkson University, Potsdam, NY 13699-5643
Tele: 315-268-6633 Fax: 315-268-6448

Name _____ Date of Birth _____ Student # _____
Month Day Year

Part I - to be completed and signed by your health care provider

Required Immunizations - Please list as Month/Day/Year

MMR (2 doses required) _____

Td (adult) (must be within 10 years) _____ OR Tdap _____

PPD (SEE PART III TUBERCULOSIS SCREENING)

RECOMMENDED IMMUNIZATIONS-PLEASE LIST AS MONTH/DAY/YEAR

Chicken Pox Vaccine _____ HPV Vaccine _____

HAV/HBV (twinrix) _____

Hepatitis B _____

Menomune _____ OR Menactra _____

Please check if applicable:

_____ Student exempt due to medical contraindication

_____ Student exempt due to religious beliefs-requests for exemption must be in writing.

Health Care Provider Name _____ Signature _____

(Required)

Health Care Provider Telephone #: _____

Part II - only completed and signed by student, or by parent/guardian for student under the age of 18, if the student does not have valid vaccination for meningococcal disease.

Meningitis Information Response Form (NYS PHL #2167)

Check and sign

_____ I have (my child has) 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 (my child) will not obtain immunization against meningococcal meningitis disease.

Signed _____ Date _____