New York School of Interior Design
founded 1916

170 East 70 Street
New York, NY 10021
Office of the Registrar
Tel
212 472-1500
Fax
212 472-3800
www.nysid.edu

IMMUNIZATION FORM – Part 1

Immunity is required prior to registration. Please complete and return this form to the Office of the Registrar.

NYSID ID no. _____

Name (last, first, middle initial) _____ Date of Birth (month, day, year)

Address

To be completed and signed by a healthcare provider: **Dates must include month and year**

I. MMR (Measles, Mumps, Rubella) If given instead of individual immunizations

If administered during childhood:

1. ☐ Dose 1 – Immunized at 12 months or after and before five years _____
2. ☐ Dose 2 – Immunized at five years or later _____

If administered in later years, two doses need to be administered at least 30 days apart:

☐ Dose 1 _____ ☐ Dose 2 _____

or if section I (above) does not apply, complete A, B, and C below:

II. A. Measles (Rubeola): Check appropriate box

1. ☐ Had disease; confirmed by record office _____
2. ☐ Has report of immune titer. Specify date of titer: _____
3. ☐ Immunized twice with live measles vaccine at 12 months after birth or later:
   ☐ Dose 1 _____ ☐ Dose 2 _____

B. Mumps: Check appropriate box

1. ☐ Had disease; confirmed by record office _____
2. ☐ Has report of immune titer. Specify date of titer: _____
3. ☐ Immunized with vaccine at 12 months after birth or later: _____

C. Rubella (German Measles): Check appropriate box (*Physician's diagnosis of rubella is not acceptable*)

1. ☐ Has report of immune titer. Specify date of titer: _____
2. ☐ Immunized with vaccine at 12 months after birth or later: _____

Healthcare Provider:

Name

Address Telephone

Signature Date

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Please check the ONE statement below that applies to you and sign where indicated:

☐ I have (or parent/guardian of student under the age of 18: My child has) had meningococcal meningitis immunization within the past 10 years.

Date _____

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease included with this form. I will (or parent/guardian of student under the age of 18: my child will) obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider.

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease included with this form. I understand the risks of not receiving the vaccine. I have decided that I will **not** (or parent/guardian of student under the age of 18: my child will not) obtain immunization against meningococcal meningitis disease.

Student Signature (Parent/Guardian if student is a minor) Date