VaughnCollege
of aeronautics and technology

# 2024-2025 Immunization Form

**Return to: Student Affairs office in W142, mail to 86-01 23rd Ave, East Elmhurst, NY 11369 or email incidents@vaughn.edu.**

Student's Name: ___________________________ Date of Birth: ____________________________

Cell Phone: # ___________________________ SONIS #: ____________________________

**<u>Mandatory Immunizations: To be completed by healthcare provider</u>**

New York State Health Law: Exact dates (MM/DD/YYYY) are required for all immunizations. Proof of immunity by titer is also acceptable. Copy of lab results must be attached.

**MMR:** (2 doses required, 1st dose must be on or after 1st birthday)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ or ☐ immune by ____/____/____

OR

**Measles:** (2 doses required, 1st dose must be on or after 1st birthday)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ or ☐ immune by ____/____/____

**Mumps:** (2 doses required, 1st dose must be on or after 1st birthday)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ or ☐ immune by ____/____/____

**Rubella:** (2 doses required, 1st dose must be on or after 1st birthday)

☐ 1st dose ____/____/____ and ☐ 2nd dose ____/____/____ or ☐ immune by ____/____/____

**Meningitis Vaccine**

☐ Not vaccinated (Must sign waiver below) ☐ Vaccinated: ____/____/____

<u>Resident Students:</u> You must document that you received either Menactra® <u>or</u> Menveo® at or after age 16 to live in the residence halls.

**If the Meningitis Vaccine has *<u>NOT</u>* been received, review the Meningitis Information on the college website:** https://www.vaughn.edu/immunization/ before signing this waiver. I have read or have had the information regarding Meningococcal Meningitis disease explained to me. I understand the risks of **not** receiving the vaccine. I have decided that I **<u>or</u>** my child if he/she is under the age of 18 years old will not receive the immunization against Meningococcal Meningitis disease.

**Signature:** __________________________________________________ **Date:** _________

Healthcare Provider Signature: _________________________ Office Address (Stamp Here):

Healthcare Provider Name: ___________________________

State/License #: ______________________________________