Dear New TC Student:

New York State Public Law 2165 requires students to provide the College with documentation of immunity to measles, mumps and rubella. Moreover, New York State Public Law 2167 requires each student to certify their decision regarding the meningococcal meningitis vaccination. These immunization requirements apply to all registered students; but are required for students taking 6 credits or more at the College. Please read the following guidelines and adhere to the procedures for compliance.

**Measles, Mumps, & Rubella Immunization Requirements**

New York State Public Law 2165 requires all students born on or after January 1, 1957 to provide the College with documentation of immunity to measles, mumps, and rubella. Immunity can be documented by providing *exact dates* of immunization shots, OR by providing results of positive blood test (titers), OR in the case of measles and mumps, by providing dates of physician diagnosis of the disease. In each case, the documents must be signed and dated by a health care provider. Religious and medical exemptions are available. Free MMR vaccinations are available for college/graduate students through the New York City Department of Health. Please visit the Immunization Requirements page on our website for more information: www.tc.edu/health.

*** If you were born BEFORE January 1, 1957, you are not required to provide proof of MMR, but you are required to complete the meningitis vaccination response as indicated below. Please make sure that your date of birth is on file with the Office of the Registrar.

**Meningococcal Vaccination Response**

On July 22, 2003, Governor Pataki signed New York State Public Health Law (NYS PHL) §2167 requiring institutions, including colleges and universities, to distribute information about meningococcal disease and vaccination to all students meeting the enrollment criteria, whether they live on or off campus. This law became effective on August 15, 2003.

Teachers College, Columbia University is required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information signed by the student. This must include information on the availability and cost of meningococcal meningitis vaccine (Menomune or Menectra); AND EITHER,
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student.

**About Meningitis:**

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death. Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease. To learn more about meningitis and the vaccine, please feel free to contact the Office of Insurance and Immunization Records at Teachers College, Health Services on the Columbia University campus, and/or consult your physician. You can also find information about the disease on the Health Services at Columbia web site: www.health.columbia.edu/cur/news/vaccines/meningitis.html, or New York State Department of Health website: www.health.state.ny.us.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States – types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students. Columbia University Health Services offers the meningococcal immunization vaccine **by appointment** for an additional cost. They are located on the 3rd & 4th floors at John Jay Hall (W. 114th & Amsterdam Ave.) on the Columbia University main campus. To make an appointment, please call (212) 854-7426.
NAME _________________________          __________________________ DATE OF BIRTH   _______/_____/________
(Please Print) Last / Family                First / Given                            Month      Day     Year

TC ID #:   T____________________________

PART I – MENINGITIS VACCINATION RESPONSE
REQUIRED BY ALL STUDENTS REGARDLESS OF AGE
(MUST BE COMPLETED AND SIGNED BY STUDENT)

Please check one box and sign below.

I have:            Month / Day / Year
☐ had the meningococcal meningitis immunization within the past 10 years.   _____/_____/_____

☐ 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.

Signed ____________________________________________________     Date _________________________________
(Student’s Signature)

PART II – PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA
TO BE IN COMPLIANCE, YOU MUST HAVE BOTH ITEMS IN SECTION A…
(MUST BE SIGNED/STAMPED BY A HEALTH CARE PROVIDER)

A. M.M.R. (Measles, Mumps, Rubella) If given instead of individual immunization

1st Dose:  Immunized on or after first birthday                 _____/_____/_____

2nd Dose:  Immunized 15 months after birth or later                                                             _____/_____/_____

OR

B: MEASLES (Rubeola)  Month / Day / Year

1. _____ Had the disease, confirmed by office record

2. ______ Date of Immune Titer – MUST SUBMIT COPY OF LAB REPORT

3. ______ Dose 1: Immunized on or after first birthday

   AND

   Dose 2: Immunized 15 months after birth or later


C: MUMPS  Month / Day / Year

1. _____ Had the disease, confirmed by office record

2. ______ Date of Immune Titer – MUST SUBMIT COPY OF LAB REPORT


D: RUBELLA  Month / Day / Year

1. ______ Date of Immune Titer – MUST SUBMIT COPY OF LAB REPORT

2. ______ Immunized on or after first birthday

Name of Health Care Provider  _________________________________________________________________

Signature of Health Care Provider  _________________________________________________________________

Address of Health Care Provider  _________________________________________________________________