THE CURE CENTER
FOR ULTRASOUND RESEARCH & EDUCATION

1-855-843-2873
info@cure.edu
www.cure.edu

MANDATORY IMMUNIZATION FORM

Last Name: First Name: Middle:

City/State/Zip:

Date of Birth: Social Security #:

Phone: Gender: (Circle One) Male Female

MMR COMBO (Measles, Mumps, Rubella) Two Doses OR One Dose and Positive Titer, OR Statement from Physician of History of Having Disease, OR Proof of Honorable Discharge from Military.

Note: Proof of Attendance in US School since 1980 is Valid For 1 Dose.

1) ____ /____ /____ (date) Given at _____

2) ____ /____ /____ (date) Given at _____

HEPATITIS B VACCINE: Three doses.

1) ____ /____ /____ (date) Given at _____

2) ____ /____ /____ (date) Given at _____

3) ____ /_____ /____ (date) Given at _____

TUBERCULIN SKIN TEST

This test is to certify that the above-named individual is free of active tuberculosis.

This is based on A **TUBERCULIN SKIN TEST** GIVEN ON _____indicating ____**mm.**

Signature M.D. or Nurse **Printed Name** **Date**

In the event of allergic reaction to TB skin test or a positive skin test result, a chest x-ray or medical doctor's evaluation is required to rule out active tuberculosis.

Date of Chest X-Ray/Physician Assessment:

Findings:

Signature M.D. or Nurse **Printed Name** **Date**

STATEMENT OF GOOD HEALTH

I hereby certify that _____is in good health based on my assessment today.

Signature M.D. or Nurse **Printed Name** **Date**

Address Phone Number

City, State, Zip

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MENINGOCOCCAL MENINGITIS RESPONSE FORM

Failure to complete the following will result in being unable to attend **CURE. THIS LAW APPLIES TO ALL STUDENTS.**

New York State Public Health Law 2167 requires that all college, university, and proprietary school students, complete the following form and be provided with information regarding Meningococcal Meningitis:

Means of transmission
Benefits, Risks and Effectiveness of Immunization
Availability and Cost of Immunization

I, _____ acknowledge receipt of the above information.

(print name)

I understand the material that has been provided to me by **CURE**, and will make an informed decision about being vaccinated for **Meningococcal Meningitis.**

Check one box and sign below.
I have (for students under the age of 18: My child has):
□ Had meningococcal meningitis immunization within the past 10 years. Date: _____)
[Note: If you (your child) received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.]

□ Read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider or another authorized medical provider.

□ 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 _____

(Parent / Guardian if student is a minor)

Print Student's name _____ Date of Birth _____

Student Mailing Address _____

Student E-mail address _____ Student SS # _____

Student Phone Number _____