IMMUNIZATION REQUIREMENTS - MEASLES, MUMPS, AND RUBELLA (MMR) VACCINATION

New York State Public Health Law 2165 requires that undergraduate, graduate, and professional students taking 6 or more credit hours demonstrate acceptable proof of immunity against measles, mumps and rubella to the schools in which they are enrolling.

Students who are not in full compliance with the requirements of the New York State Public Health Law 2165 **will NOT be allowed to remain enrolled in courses** after 30 days from the start of the term and may forfeit all or part of their tuition.

REQUIRED VACCINES:

- Measles – 2 doses of live vaccine: the first given no more than 4 days before your first birthday, and the second at least 28 days after the first
- Mumps – 1 dose
- Rubella – 1 dose

ACCEPTABLE PROOF OF IMMUNITY:

- Certified Vaccination Administration Record from your doctor
- Immunization records from your undergraduate institution, high school, or the armed services
- Physician documented proof of disease (not acceptable for rubella)
- Blood tests proving immunity to Measles, Mumps and Rubella (a.k.a. Blood Antibody Titer)

EXCEPTIONS:

- If you are a student born before January 1, 1957
- If you are unable to receive a vaccine for medical reasons your doctor must write a note to this effect and signs it.
- If you are unable to receive a vaccine for religious reasons, you must submit documentation. In the event of an outbreak of measles, mumps or rubella, you may not be allowed to attend classes or remain on campus.
- Entering students are required to submit proof of immunity (usually 2 MMR vaccinations) or documentation of medical or religious exemption. Medical exemptions must be certified by a licensed physician, physician assistant or nurse practitioner.

Return to:

Fei Tian College–Middletown
Office of Admissions
14 Jason Place
Middletown, NY 10940
Phone: (845) 293-2608
Email: admissions@mt.feitian.edu

MENINGITIS VACCINATION RESPONSE FORM

Last Name:	First Name:	Date of Birth:
Gender:	Student ID #:	Cell Phone:
Home Address:		
Email:		

New York State Public Health Law 2167 requires that colleges and universities distribute information about meningococcal disease and vaccinations to all students enrolled for at least 6 credit hours.

It is mandatory that you review this information, sign, and return this form to the college.

Check one box and sign below

I have (for students under the age of 18: My child has)

- ☐ had the meningococcal meningitis immunization (Menomune/Menactra/Menveo TM) within the past 5 years. The vaccine record is attached.
- ☐ 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.
- ☐ 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 ___________________

(Student or Parent/Guardian if student is under 18)

Print Parent/Guardian Name ____________________________

Turn over for the Meningococcal Disease Fact Sheet

Meningococcal Disease

What is meningococcal disease? Meningococcal disease is caused by bacteria called Neisseria meningitides. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications, including death.
Who is at risk? Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are: teenagers or young adults**,** infants younger than one year of age**,** living in crowded settings, such as college dormitories or military barracks**,** traveling to areas outside of the United States, such as the "meningitis belt" in Africa**,** Living with a damaged spleen or no spleen**,** Being treated with Soliris® or, who have complement component deficiency (an inherited immune disorder)**,** Exposed during an outbreak**,** working with meningococcal bacteria in a laboratory.
What are the symptoms? Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include: A sudden high fever**,** Headache, Stiff neck (meningitis), Nausea and vomiting, Red- purple skin rash, Weakness and feeling very ill, Eyes sensitive to light.
How is meningococcal disease spread? It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.
Is there treatment? Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long- term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.
What are the complications? Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include: hearing loss**,** brain damage**,** kidney damage**,** limb amputations.
What should I do if I or someone close to me is exposed? If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.
What is the best way to prevent meningococcal disease? The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease. All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is given at 11 to 12 years of age, and the second dose (booster) at age 16. It is very important that teens receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease. Teens and young adults can also be vaccinated against the "B" strain. Talk to your health care provider if you have not received two doses of vaccine against meningococcal strains A, C, W and Y or against the "B" strain.
Who else should receive the vaccine? Infants, People with certain medical conditions, People exposed during an outbreak, Travelers to the "meningitis belt" of sub-Saharan Africa, Military recruits. Please speak with your health care provider if you may be at increased risk.
What are the meningococcal vaccine requirements for school attendance? As of September 1, 2016, children entering grades 7 and 12 must be immunized against meningococcal disease strains A, C, W and Y according to the recommendations listed above.
Is there an increased risk for meningococcal disease if I travel? Meningococcal disease and outbreaks occur in the United States and around the world. The disease is more common in the "meningitis belt" of sub- Saharan Africa. The risk is highest in people who visit these countries and who have prolonged contact with local populations during an epidemic. To reduce your risk of illness, wash your hands often, maintain healthy habits such as getting plenty of rest and try not to come into contact with people who are sick.

Travel and meningococcal disease:
wwwnc.cdc.gov/travel/diseases/meningococcal-disease

Learn more about meningococcal disease:
www.cdc.gov/meningococcal/

For more information about vaccine-preventable diseases:
www.health.ny.gov/prevention/immunization/

HEALTH HISTORY FORM

Last Name:	First Name:	Date of Birth:
Gender:	Student ID #:	Date:

I. Life Threatening Allergic Conditions: (Check all that apply)

☐ Severe allergic reaction to Bee Stings, other insects ____________________

☐ Severe reaction to Nuts, Peanuts: ____________________

☐ Severe reaction to other Food Products: ____________________

☐ Other severe allergies affecting school: ____________________

Please indicate any of your symptoms which would indicate a severe allergy: (Local swelling does not indicate a severe allergic reaction.)

☐ Itching and/or tightness in the throat, hoarseness

☐ Itching or swelling of the eyes, lips, tongue or mouth

☐ Shortness of breath, coughing, and/or wheezing

☐ "Thready pulse", "passing out"/loss of consciousness

☐ Hives

II. Health Conditions: Have you been diagnosed by a physician with any of the following? Check "Yes" or "No". Provide dates and details for all items checked "Yes".

Yes	No	Condition	Details/Dates
		Attention deficit:___ADD or___ADHD Date diagnosed_________________Meds:___Yes___No	
		Allergies to medications	
		Allergies (environmental or seasonal)	
		Asthma/Reactive Airway Uses an inhaler?_____Yes___No Uses a nebulizer?____Yes___No	
		Autism/PDD:___Autism or___Aspergers or____PDD-NOS (not otherwise specified)	
		Behavior problem	
		Bleeding disorder	
		Bowel or digestive problem	
		Cancer, Type: ______________________________________ Date diagnosed __________________	
		Cerebral Palsy	
		Chromosomal disorder:____Down's syndrome____Other – specify →	
		Cleft lip/palate	
		Cystic Fibrosis	
		Dental problem	
		Depression	

Yes	No	Condition	Details/Dates
		Diabetes: Date diagnosed _______________ Insulin Dependent:____Yes___No	
		Eating disorder:____Anorexia___Bulemia	
		Emotional disorder	
		Growth problems	
		Heart problem: specify →	
		Hepatitis, Type: _____________________________________ Date diagnosed _________________	
		Hernia	
		High blood pressure	
		Hospitalizations: specify →	
		Immunodeficiency disease	
		Kidney or urinary problem	
		Lyme disease	
		Muscular disorder	
		Migraine headaches	
		Nutritional/weight problem	
		Orthopedic problem (bone, joint)	
		Pregnancy	
		Rheumatoid Arthritis	
		Scoliosis/abnormal spinal curve: Date of diagnosis _________________ Date of last evaluation ________________	
		Seizure disorder, Type __________________________________ Date of last seizure:________________ Meds:___Yes___No. Medication ________________________ (Please provide physician documentation of diagnosis.)	
		Self Harm/Mutilation	
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Substance abuse (alcohol, drugs, tobacco)	
		Suicide risk or attempt	
		Surgeries: specify →	
		Thyroid disorder	
		Tics or twitches	
		Tourette's syndrome	
		Tuberculosis	
		Other	

Yes	No	HEARING	
		Hearing loss: [ ] Right -___Mild___Moderate____Severe [ ] Left -___Mild___Moderate____Severe Hearing aid [ ] Right [ ] Left	Hearing loss due to _______________________ Last evaluation _________________________

Yes	No	Vision
		Color deficiency
		Legally blind
		Vision problem/Eye defect___________________________________Last eye exam _____
		Wears glasses [ ] All the time [ ] For distance only [ ] For reading only [ ] For sports
		Wears contact lenses

III. Medications: (Include prescription and over-the-counter medication)

Name__________________________________Used to Treat___________________________________

__________________________________ __________________________________

__________________________________ __________________________________

IV. Special Needs

Are there any other medical diagnoses or disabling conditions that might require a modification in your activities at the College?

[ ] Yes* [ ] No Specify: ____

____

* Any condition that would prevent full participation in educational programs requires physician documentation before modifications can be considered.

___________________________________ ______________________________

Student's or Guardian's Signature Date

Health Insurance & Emergency Contact

Last Name:	First Name:	Date of Birth:
Gender:	Student ID #:	Cell Phone:

Medical Information

Hospital/Clinic Preference: ____

Physician's Name: __________________________ Phone #: ______________________

Health Insurance *

Insurance Company: _________________________ Group Number: ________________

Type of Insurance: __________________________ Policy (ID) Number: _____________

*Please attached a copy of your insurance card (front & back)

Emergency Contact

Name (Contact 1):__________________________ Relationship: ___________________

Cell #:___________________Home #:____________________Work #:_________________

Name (Contact 2):__________________________ Relationship: ___________________

Cell #:___________________Home #:____________________Work #:_________________

MEDICAL AUTHORIZATION AND CONSENT FROM

Last Name:	First Name:	Date of Birth:
Gender:	Student ID #:	Cell Phone:

FOR STUDENT 18 OR OVER AT THE START OF 2021 FALL

SEMESTER: I hereby consent to treatment by Fei Tian College Health Office

staff. __________________________________ _______________________

Student signature: **OR** Date:

FOR PARENTS OF STUDENTS WHO WILL BE UNDER 18 YEARS OF AGE AT THE START OF THE 2022 FALL SEMESTER: (STUDENTS UNDER 18 YEARS OLD CANNOT RECEIVE TREATMENT WITHOUT PARENTAL CONSENT)

I hereby consent for Fei Tian College Health Office to treat the above named student in the event that I cannot be contacted, or in the judgment of medical professionals, immediate attention is required prior to my being contacted.

Parent/Guardian Signature: ________________________________ Date: _______________________

Print Parent/Guardian Name: _____________________________ Relationship: __________________

Parents, please note: Parental notification of treatment for illness or injury of any student over 18 years of age is the responsibility of the student. Fei Tian College staff will actively encourage students to inform their parents/guardians of illness, injury, or medical treatment.

OPTIONAL CONSENT TO DISCUSS MEDICAL CONDITION FOR STUDENTS 18 AND OLDER:

I hereby give my consent to Fei Tian College Health Office to discuss my medical condition with my parent(s) or guardian(s), listed below. I understand that I can withdraw this permission at any time.

Parent(s) or Guardian(s):

Name: ______________________________________ Relationship: ____________________________

Name: ______________________________________ Relationship: ____________________________

Student signature:_________________________________ Date: ___________________________