Pre-Registration Immunization Form

COLUMBIA HEALTH

For Morningside, Manhattanville, and Teachers College students only.
Visit the **Columbia Health website** *for additional information.*

This section to be completed by the student:

Legal Last Name: _____ Legal First Name: _____ Middle Initial: ___

Date of Birth (MM/DD/YYYY): ___/___/_____ School/Program: _____

UNI: _____ Email Address: _____

☐ I will certify my informed meningitis decision in the Medical Clearances section of the Patient Portal. **If you indicate that you received the meningitis vaccine within the past 5 years, the medical provider must take action below.*

This section must be completed by a medical provider who is not a relative:
This form will not be accepted until the following section is fully completed by a medical provider.

Measles (Rubeola), Mumps, Rubella (MMR) Upload supporting documentation to the **Patient Portal, Medical Clearances** section. All records must include name and date of birth.	**Vaccine:**	**Date: MM/DD/YYYY**
Option A: MMR Immunizations (on or after first birthday and at least 28 days apart)	MMR Dose 1	___/___/_____
	MMR Dose 2	___/___/_____
Option B: Measles, Mumps, and Rubella Immunizations given separately (on or after first birthday and at least 28 days apart)	Measles Dose 1	___/___/_____
	Measles Dose 2	___/___/_____
	Mumps Dose 1	___/___/_____
	Rubella Dose 1	___/___/_____
Option C: Positive MMR IgG Antibody titers **(lab reports required)**	Measles (Rubeola) Titer	___/___/_____
	Mumps Titer	___/___/_____
	Rubella Titer	___/___/_____
Meningitis Vaccine (only if you indicated receipt of a meningococcal vaccine within the past 5 years on the decision form in the Patient Portal)		
Option A: Meningococcal type B immunizations (2 doses received at least 6 months apart within the past 5 years)	MenB Dose 1	___/___/_____
	MenB Dose 2	___/___/_____
Option B: Men ACWY Dose 1 or Men ABCWY Dose 1 (received within the past 5 years)	MenACWY Dose 1	___/___/_____
	MenABCWY Dose 1	___/___/_____

I attest that all dates, results, and immunizations listed on this form are correct and accurate.

_____ Date: ___/___/_____
Medical Provider's Printed Name:

_____ _____
Medical Provider's Signature & Stamp (Both required): License Number:

Last updated March 2025