BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

Decker Student Health Services Center
Phone: 607-777-2221
Fax: 607-777-2881
https://binghamton.medicatconnect.com/

INSTRUCTIONS FOR SUBMISSION OF MANDATORY HEALTH FORMS

Failure to meet these requirements will place holds that block you from registering for your courses.

☐ **CERTIFICATE OF IMMUNIZATION**

- Record of 2 MMR's (or documentation of 2 Measles, 1 Mumps, and 1 Rubella) is required by New York State law for entrance into Binghamton University
- There are 2 ways you can send us this information.
  1. Certificate of Immunization completed and signed by healthcare provider

OR

  2. **OFFICIAL DOCUMENTATION*** of your immunization history.

You do not need to send both forms if required information is complete on one form

☐ **MENINGOCOCCAL VACCINATION RESPONSE FORM**

The following is acceptable to meet the Meningitis requirement**:**

- A vaccine record indicating at least 1 dose of Meningococcal ACWY vaccine within the last 5 years or a complete 2- or 3-dose series of MenB.

OR

- A signed response form indicating that the student will obtain Meningococcal vaccine within 30 days.

OR

- A signed response form indicating that the student will not obtain immunization against Meningococcal disease.

If the student has not received Meningococcal Vaccine within the past 5 years, they MUST submit the signed response form

Students can find the Meningococcal Vaccination Response Form at: https://binghamton.medicatconnect.com/.
You will need your Binghamton University Computer Account username and password to log into this site.

☐ **MEDICAL/HEALTH HISTORY/TUBERCULOSIS QUESTIONNAIRE**

Complete this form online, via our Patient Portal at https://binghamton.medicatconnect.com/.
You will need your Binghamton University computer account username and password.
Once logged in, select FORM near the top. Select and complete the Medical/Health History/Tuberculosis Questionnaire.
*The Tuberculosis requirement must be submitted **PRIOR** to registration for the **NEXT** semester. However, it is best for you to complete this requirement as soon as possible to avoid any holds for the **NEXT** semester.*

☐ **UNDER 18 CONSENT FORM**

New students who are **UNDER AGE 18** must have their parent/guardian complete this form to authorize Decker Student Health Services Center staff to provide medical or emergency treatment to the underage student.

Forms may be submitted in **ONE** of the following ways:	
Mail: Decker Student Health Services Center Binghamton University P.O. Box 6000 Binghamton, NY 13902-6000 USA.	**Upload:** Via the Patient Portal: (https://binghamton.medicatconnect.com/) You can scan and upload your documents by clicking on UPLOAD at the top of the Patient Portal and follow instructions.

***Official Documentation: Documents including physician-verified history of disease, laboratory evidence of immunity (titers), personal records, (i.e., baby book with official medical provider's signature or office stamp), or medical exemption. Other acceptable documents include a copy of the immunization record from a prior school (high school or college), a migrant health record, a union health record, a community health plan record, a signed immunization transfer card, a military dependent's "shot" record, the immunization portion of a passport, an immunization record card signed by a physician, physician assistant or nurse practitioner, or an immunization registry record.**

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CERTIFICATE OF IMMUNIZATION

Last Name:		First Name:	
BNumber:	Local Phone:	Permanent Phone:	Date of Birth (mm/dd/yy):

REQUIRED IMMUNIZATIONS

Measles, Mumps, Rubella For all born after 12/31/1956, 2 doses (dose 1 must be administered at least 361 days after birth and 2nd dose given a minimum of 4 weeks later) or a blood test showing immunity. **Please attach any titer documentation.**	**1st MMR Dose** ____/____/____ Month Day Year	**2nd MMR Dose** ____/____/____ Month Day Year	**3rd MMR Dose** ____/____/____ Month Day Year

Measles Dose 1 ____/____/____ Month Day Year	**Measles Dose 2** ____/____/____ Month Day Year	**Mumps Dose 1** ____/____/____ Month Day Year	**Rubella Dose 1** ____/____/____ Month Day Year

Meningococcal (serogroups A, C, W, Y) If you have not entered an administration date that is within 5 years for the Meningococcal Vaccine (serogroup A, C, W, Y) you must acknowledge that you have reviewed the meningitis disease vaccine information https://www.binghamton.edu/health/docs/information_about_the_meningococcal_meningitis_vaccine_health_requirement.pdf and, with your below signature, acknowledge that you are aware of the meningococcal disease risks and that you decline the meningococcal meningitis immunization.	____/____/____ Month Day Year ____/____/____ Month Day Year	☐ Menactra ☐ Menveo ☐ MCV4 (A, C, Y, W-135) ☐ Other ☐ Menactra ☐ Menveo ☐ MCV4 (A, C, Y, W-135) ☐ Other

Signature of Student or Parent/Guardian if Student is Under 18 Years of Age

Tuberculosis **BINGHAMTON UNIVERSITY DOES NOT ACCEPT TB SKIN TEST (PPD) RESULTS PLACED BY PROVIDERS OUTSIDE THE UNITED STATES OR CANADA.** Please go to https://www.binghamton.edu/health/new-student-information.html for information regarding this requirement.

NON-REQUIRED IMMUNIZATIONS ☐

Tetanus-Diphtheria and Pertussis Record date and type of **most recent** tetanus-diphtheria vaccine.	____/____/____ Month Day Year	☐ Tdap ☐ Td

Gardasil HPV Vaccine	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	**Dose 3** ____/____/____ Month Day Year
Hepatitis B Vaccine	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	**Dose 3** ____/____/____ Month Day Year
Varicella Vaccine (Chicken Pox)	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	**Illness** ____/____/____ Month Day Year
Hepatitis A Vaccine	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	☐
Meningococcal Vaccine (serogroup B)	**Dose 1** ____/____/____ Month Day Year	**Dose 2** ____/____/____ Month Day Year	**Dose 3** ____/____/____ Month Day Year ☐ Bexsero ☐ Trumenba

Health Care Provider Information

Provider Name (Please Print):		Title:
Signature:	Phone:	Date: ____/____/____ Month Day Year
Address:		