



C.W. POST CAMPUS  
720 Northern Blvd. • Brookville, New York 11548-1300

Student Health & Counseling Center  
516 -299-2345

Dear C.W. Post Student:

All students who were born after December 31, 1956 **MUST** submit an immunization record. This proof consists of either documentation of receipt of vaccine, serological proof of immunity (copy of the actual laboratory report) or proof from the treating doctor of having had Measles or Mumps. The State does **not** accept report of disease for Rubella. N.Y. State residents are allowed 30 days and non N.Y. State resident students 45 days from the start of classes to **complete** this requirement. **ALL on-campus resident students and athletes MUST ALSO** submit a completed health form including TST (I.D. Mantoux) test done within the last 12 months, to the Student Health & Counseling office.

According to our records you have not yet submitted the required documentation. If you are getting your immunization record from a previous school you have attended it must be on the school stationery with the official school stamp and signed by an appropriate medical professional. Failure to comply with these State requirements may result in **CANCELLATION** of your registration. If you have already submitted this information please disregard this letter. Your immunization status can be checked on the LIU website at: <http://www.liu.edu> and sign in to your MYLIU account.

Please forward the documentation to: C.W. Post Campus of L.I.U.  
Student Health Services - Life Science Bldg., Room 154  
720 Northern Blvd., Brookville, N.Y. 11548  
Phone: (516) 299-2345 Fax: (516) 299-4113

**DO NOT DETACH**

**IMMUNIZATION HISTORY**

(To be completed **ONLY** by your **PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT**)

STUDENT NAME \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

STUDENT I.D. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ E-Mail \_\_\_\_\_

COMPLETE DATES (Month/ Day/Year) of Immunizations OR Dates (M/D/Y) of Disease OR Titre \*

	Date(s) of Immunization		Date of Disease	Titre*
MMR	1st	2nd		*MUST attach
MMR Vz	1st	2nd		a copy of
Varicella				actual laboratory
Rubeola				report for any
Mumps				titre result(s)
Rubella			NOT acceptable	
Menomune/Menactra				

Physician's Signature \_\_\_\_\_ M.D. Reg # \_\_\_\_\_

Print Name \_\_\_\_\_

Address & Office Stamp (**REQUIRED**) \_\_\_\_\_

Date \_\_\_\_\_