MUST BE COMPLETED, SIGNED & OFFICE STAMPED BY A HEALTHCARE PROVIDER

RECORD OF IMMUNIZATION

Student's Name: ______________________________ **Birth date:** ____/____/____
Last *First* *M D Y*

REQUIRED FOR ALL STUDENTS.

MEASLES, MUMPS, RUBELLA (MMR) (students born BEFORE 1957 are exempt from the MMR requirement)			
OR → ↓	**2 doses of MMR VACCINE** **Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE:** ____/____/____ *M D Y* **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:** ____/____/____ *M D Y*	**OR**	**LABORATORY PROOF OF IMMUNITY** (see below) ↓
2 doses of MEASLES VACCINE **Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE:** ____/____/____ *M D Y* **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:** ____/____/____ *M D Y*		**OR**	MEASLES Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
2 doses of MUMPS VACCINE **Dose 1 RECEIVED ≥ 12 MONTHS OF AGE:** ____/____/____ *M D Y* **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:** ____/____/____ *M D Y*		**OR**	MUMPS Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
1 dose of RUBELLA VACCINE **Dose 1 RECEIVED ≥ 12 MONTHS OF AGE:** ____/____/____ *M D Y*		**OR**	RUBELLA Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.

REQUIRED ONLY FOR STUDENTS TAKING 9 OR MORE TCNJ CREDITS THEIR 1ST SEMESTER/TERM.

HEPATITIS B - (NOTE: If beginning vaccination series, no need to accelerate dosing. Series can be completed at TCNJ)				
3 doses of HEPATITIS B VACCINE Dose 1: ____/____/____ *M D Y* Dose 2: ____/____/____ *M D Y* Dose 3: ____/____/____ *M D Y*	**OR**	**3 doses of Combined HEPATITIS A & HEPATITIS B VACCINE** Dose 1: ____/____/____ *M D Y* Dose 2: ____/____/____ *M D Y* Dose 3: ____/____/____ *M D Y*	**OR**	**LABORATORY PROOF OF DISEASE OR IMMUNITY TO HEPATITIS B** Copy of laboratory report must be attached.

rev June 2015

Record of Immunization is not valid unless signed & stamped by a PHYSICIAN, PA, APN or RN

Print Name & Title: ______________________________

Signature: ______________________________

Date: ______________ Office Telephone: (   ) ______________

Office Stamp (REQUIRED)