

RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY

For undergraduate students and CCS students starting classes at TCNJ in Fall 2021 - Spring 2023

You are not required to use this form. However, it is important that you use it as a guide to required vaccinations.

An official immunization record from your healthcare provider, pharmacist, previous school, armed forces, or employer can be substituted.

Student's Name: (last) _____ (first) _____		Birth date: ___/___/___ M D Y
Student's cell phone #: _____	PAWS ID #: _____	Starting Term: ___ Fall ___ Winter ___ Summer ___ EOF ___ Spring
I will reside on campus: ___ Yes ___ No		I will be a full-time student (taking 3 or more course units per semester): ___ Yes ___ No

The rest of this form is to be completed, signed, and office-stamped by a physician, nurse practitioner, registered nurse, or physician assistant.

MEASLES, MUMPS, RUBELLA (MMR). REQUIRED. (note: student born BEFORE 1957 are exempt from the MMR requirement)			
OR → ↓	2 doses of MMR VACCINE Dose #1 RECEIVED at or after 12 MONTHS OF AGE: ___/___/___ M D Y Dose #2 RECEIVED 28 DAYS or more after Dose 1: ___/___/___ M D Y	OR	LABORATORY TEST REPORT of IMMUNITY (see below) ↓
2 doses of MEASLES VACCINE Dose #1 RECEIVED AFTER 1968 AND at or after 12 MONTHS OF AGE: ___/___/___ M D Y Dose #2 RECEIVED 28 DAYS or more after Dose 1: ___/___/___ 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 at or after 12 MONTHS OF AGE: ___/___/___ M D Y Dose #2 RECEIVED 28 DAYS or more after Dose 1: ___/___/___ M D Y		OR	MUMPS Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
1 dose of RUBELLA VACCINE RECEIVED at or after 12 MONTHS OF AGE: ___/___/___ M D Y		OR	RUBELLA Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
VARICELLA (Chickenpox). REQUIRED.			
2 doses of VARICELLA VACCINE Dose #1 RECEIVED at or after 12 MO OF AGE: ___/___/___ M D Y Dose #2 RECEIVED 28 DAYS or more after Dose 1: ___/___/___ M D Y	OR	LABORATORY PROOF OF IMMUNITY Varicella Zoster Virus (VZV) IgG Antibody test. Copy of laboratory report must be attached.	OR PAST HISTORY of Chickenpox or herpes ZOSTER (Shingles) based on healthcare provider diagnosis. Date: ___/___/___ M D Y
COVID-19 vaccination: Primary Series. REQUIRED.		COVID-19 Booster. RECOMMENDED.	
CHECK ONE: <input type="checkbox"/> Pfizer-Biotech <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> J&J/Janssen Dose #1: ___/___/___ Dose #2: ___/___/___ M D Y M D Y		MOST RECENT BOOSTER if more than one booster received: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> J&J/Janssen ___/___/___ M D Y	
TETANUS, DIPHTHERIA, PERTUSSIS (Tdap or Td) vaccination. REQUIRED.			
1 dose of TDAP RECEIVED within the last 10 YEARS: ___/___/___ M D Y			

Student's Name: _____
Last
First

Birth date: ____/____/____
M
D
Y

HEPATITIS B. REQUIRED FOR FULL-TIME STUDENTS (Full-Time = 3 or more course units/semester). NOTE: If starting vaccination series, vaccinations can be completed at TCNJ; no need to accelerate doses.			
3-4 doses of Hepatitis B vaccine Enderix-B® (GSK) or Recombivax HB® (Merck) depending on schedule used. Dose #1: ____/____/____ M D Y Dose #2: ____/____/____ M D Y Dose #3: ____/____/____ M D Y Dose #4: ____/____/____ M D Y	OR	2 doses of Recombivax HB® (Merck) Hepatitis B vaccine licensed for a 2-dose schedule for children aged 11-15 years only. Dose #1: ____/____/____ M D Y Dose #2: ____/____/____ M D Y	OR
2 doses of Heplisav-B® (Dynavax)	OR	3-4 doses of Combined HEPATITIS A & B VACCINE (Twinrix®) depending on schedule used. Dose #1: ____/____/____ M D Y Dose #2: ____/____/____ M D Y Dose #3: ____/____/____ M D Y Dose #4: ____/____/____ M D Y	

MENINGOCOCCAL ACWY vaccination (Menactra®; Menveo®). REQUIRED	
One dose received AT OR AFTER AGE 16 is REQUIRED for all students who are <ul style="list-style-type: none"> 18 years of age and younger 19 years of age and older applying to live in college housing Dose received at or after age 16: ____/____/____ M D Y Previous dose received at 10-15 years of age? ____/____/____ M D Y	OR <p>For students with medical risk factors: anatomical or functional asplenia, sickle cell disease, HIV infection, persistent complement deficiency, or complement inhibitor use (e.g., Solaris®, Ultomiris®):</p> PRIMARY DOSE #1: ____/____/____ M D Y PRIMARY DOSE #2: ____/____/____ M D Y If 5 years from Dose #2, revaccinated on ____/____/____ M D Y

MEN B vaccination (Trumenba®, Bexsero®). REQUIRED only for students who have certain medical risk factors: anatomical or functional asplenia, sickle cell disease, HIV infection, persistent complement deficiency, or complement inhibitor use (e.g., Solaris®, Ultomiris®).	
MenB-FHBP (Trumenba®, Wyeth) Dose #1: ____/____/____ Dose #3: ____/____/____ M D Y M D Y Dose #2: ____/____/____ M D Y	OR MenB-4C (Bexsero®, Novartis) Dose #1: ____/____/____ M D Y Dose #2: ____/____/____ M D Y

HEPATITIS A vaccination (i.e., Havrix®, VAQTA®). RECOMMENDED.
Dose #1: ____/____/____ Dose #2: ____/____/____ M D Y M D Y

HUMAN PAPILLOMAVIRUS (HPV) vaccination. RECOMMENDED.
Dose #1: ____/____/____ Dose #2: ____/____/____ Dose #3 if administered at or after age 15 years: ____/____/____ M D Y M D Y M D Y

Record of Immunization is NOT VALID unless signed & stamped by a PHYSICIAN, PA, NP or RN

Print Name & Title: _____

Signature: _____

Date: _____ Office Telephone: () _____

Not valid without Office Stamp (REQUIRED)

