**RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY   
For undergraduate students starting classes at TCNJ in Fall 2021 through 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.

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| **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.**

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| **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:   Pfizer-Biotech  Moderna  Novavax  J&J/Janssen  Dose #1: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Dose #2:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_   *M D Y* *M D Y* | | | MOST RECENT BOOSTERif more than one booster received:   Pfizer  Moderna  J&J/Janssen  \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  *M D Y* | | |
| **TETANUS, DIPHTHERIA, PERTUSSIS (Tdap or Td) vaccination. REQUIRED.** | | | | | |
| **1 dose of TDAP** RECEIVEDwithin the last 10 YEARS**:** \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_   *M D Y* | | | | | |

PEHR 11/28/22

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**Student’s Name: Birth date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  
 *Last First* *M D Y***

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| **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 Engerix-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)**  Dose #1: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  *M D Y*    Dose #2: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  *M D Y* | | **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**   * **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** | | **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®):**  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**

**Not valid without Office Stamp (REQUIRED)**

Print Name & Title:

Signature:

Date: Office Telephone: ( )

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