RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY

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 <u>office-stamped</u> by a physician, nurse, or physician assistant.

MEASLES, MUMPS, RUBELLA (MMR) REQUIREMENT for all students born AFTER 1957.

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.

MENINGOCOCCAL ACWY vaccination (Menactra®; Menveo®) REQUIRED for the following students:

Students who are: • **18 years of age or younger** • **19 years of age or older applying to live in college housing** **are required to have one dose received AT OR AFTER AGE 16 is** **Dose received at or after age 16 is REQUIRED:** _____/_____/_____ M D Y Was an earlier dose received at 10-15 years of age? ☐ No ☐ Yes, on _____/_____/_____ M D Y	**and**	**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 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®). RECOMMENDED FOR ALL OTHER STUDENTS WHO ARE 16-23 YEARS OF AGE.

MenB-FHBP (Trumenba®, Wyeth) Dose #1: _____/_____/_____ M D Y Dose #3: _____/_____/_____ M D Y Dose #2: _____/_____/_____ M D Y	**OR**	**MenB-4C (Bexsero®, Novartis)** Dose #1: _____/_____/_____ M D Y Dose #2: _____/_____/_____ M D Y

Continued on next page

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

VARICELLA (Chickenpox) REQUIREMENT for all students.

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)

HEPATITIS B vaccination REQUIRED FOR FULL-TIME STUDENTS (Full-Time = 9 or more credits).

3-4 doses of Hepatitis B vaccine Engerix-B® (GSK), Recombivax HB® (Merck), or PreHevbrio® (VBI) 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)

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap or Td) vaccination REQUIRED for all students.

1 dose of TDAP or TD VACCINE RECEIVED within the last 10 years: ____/____/____ (M D Y) **Tdap** ☐ **Td** ☐

COVID-19 vaccination to be up-to-date: STRONG RECOMMENDATION

see https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html

Primary Series:

Dose #1: ____/____/____ (M D Y) Dose #2 ____/____/____ (M D Y)

☐ Pfizer ☐ Moderna ☐ J & J ☐ Novavax Other_____

Most recent booster: ____/____/____ (M D Y)

☐ Pfizer ☐ Moderna ☐ Novavax Other_____

HEPATITIS A vaccination (i.e., Havrix®, VAQTA®) RECOMMENDED

Dose #1: ____/____/____ (M D Y) Dose #2: ____/____/____ (M D Y)

HUMAN PAPILLOMAVIRUS (HPV) vaccination RECOMMENDED

Dose #1: ____/____/____ (M D Y) Dose #2: ____/____/____ (M D Y) Dose #3 if administered at or after age 15 years: ____/____/____ (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)