RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY

Graduate Students

You are <u>not</u> 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*

The rest of this form is to be completed, signed, and <u>office-stamped</u> 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.

HEPATITIS B. REQUIRED FOR FULL-TIME STUDENTS (Full-Time = 3 or more course units).

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*

CONTINUE TO NEXT PAGE

Student's Name: (last)	(first)	Birth date: ____/____/____ M D Y

MENINGOCOCCAL ACWY vaccination (Menactra®; Menveo®). REQUIRED FOR CERTAIN STUDENTS (See below)

One dose received AT OR AFTER AGE 16 is REQUIRED for all students who are • **19 years of age and older living 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)		**MenB-4C (Bexsero®, Novartis)**
Dose #1: ____/____/____ M D Y Dose #3: ____/____/____ M D Y Dose #2: ____/____/____ M D Y	**OR**	Dose #1: ____/____/____ M D Y Dose #2: ____/____/____ M D Y

COVID-19 Vaccine. Recommended to be up to date.

Date of most recent COVID-19 vaccine: ____/____/____ M D Y **Moderna** ☐ **Pfizer** ☐ **Novavax** ☐ **Other** ☐ _____

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)