RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY

Graduate Students

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

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.**

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 and within the past 5 years 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)

If over 5 years since dose at age 16, **and** living in college housing, revaccinated on: ____/_____/_____ (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: ____/_____/_____ (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)

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)