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 must be completed, signed, and office-stamped by a licensed healthcare provider.

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

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

1 dose of TDAP VACCINE RECEIVED within the last 10 years: ____/_____/_____ M D Y **Tdap** ☐

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Student's Name: _____ **Birth date:** ____/____/____
Last *First* *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 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 (MenQuadfi®; Menveo®). REQUIRED

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)

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)