UNIVERSITY HEALTH CENTER

HEALTH CENTER IMMUNIZATION FORM

Name:__________________________ ___________________________ ________________

Last Name First Name Middle Name

Date of Birth: _____ ______ ______ Social Security # _____ - _____ - _____ CWID#____________

Instructions:

1. **Fill in all information requested. Missing or unclear information will delay processing of these requirements.**
2. **The section for healthcare providers MUST be completed by a healthcare provider. Forms signed by students or parent/guardian can not be accepted.**
3. **All forms must be mailed to the address listed prior to the deadline.**
4. **Immunization documentation from a high school or other college/university will be accepted in place of the forms below. Copies of original immunization records from health departments or other countries will also be accepted. Please do not send originals. They will not be returned!**
5. **If you choose to request a religious exemption to immunizations, a letter must be submitted from the enrolled student stating specific religious doctrine that prohibits immunization. Letters from parents or religious leaders can not be accepted.**
6. **Individuals in need of a medical exemption for immunizations must submit a written statement from the healthcare provider that immunization is contraindicated due to a valid medical condition.**
7. **Students under the age of eighteen must have a parent or guardian sign the last section to provide consent for the University Health Center to treat the student until the age of eighteen.**
8. **Specific detail of New Jersey immunization regulations may be obtained through the Health Center website at www.montclair.edu/health/hc/ . Additional information on immunizations can be found at www.cdc.gov . Questions should be sent to askanurse.mail.montclair.edu.**
9. **Students who need immunizations to meet requirements may obtain any of the vaccines at the University Health Center. Please call (973) 655-4361 to make an appointment.**
10. **All completed forms should be mailed to:**

The University Health Center
Montclair State University
Blanton Hall, One Normal Avenue
Montclair, New Jersey 07043
Attn: Immunization Program

11. **DEADLINE:** **Fall Enrollment** **July 30**

Spring enrollment **January 2**

THIS SECTION MUST BE COMPLETED, STAMPED AND SIGNED BY YOUR HEALTH CARE PROVIDER:

Name ____ SS# _____-_____-_____ CWID#_________________________

A. Immunizations required for ALL undergraduate and graduate students born after 1956:

1. MMR (Measles/Mumps/Rubella) vaccine – 2 doses required

DOSE #1 ___/___/___ (given on or after one year of age) (M D Y) **DOSE #2 ___/___/___ (given at least 30 days after Dose #1)** (M D Y)

OR:

Measles (Rubeola) **2 doses required**	**DOSE #1 ___/___/___** (M D Y)	**DOSE #2 ___/___/___** (M D Y)	**OR**	**TITER/DATE ___/___/___** (M D Y)
Mumps **2 doses required**	**DOSE #1 ___/___/___** (M D Y)	**DOSE #2 ___/___/___** (M D Y)	**OR**	**TITER/DATE ___/___/___** (M D Y)
Rubella (German Measles) **1 dose required**	**DOSE #1 ___/___/___** (M D Y)		**OR**	**TITER/DATE ___/___/___** (M D Y)

2. Hepatitis B – series of 3 doses required

DOSE # 1 ___/___/___ (M D Y) **DOSE # 2 ___/___/___** (M D Y) **DOSE # 3 ___/___/___** (M D Y) **OR** **TITER/DATE ___/___/___** (M D Y)

A copy of laboratory report must be attached to this form if titer results are submitted as documentation.

B. Immunization required for ALL undergraduate or graduate students who intend to reside in University housing:

Meningococcal Meningitis Vaccination DATE ___/___/___ (M D Y)

HOUSING ASSIGNMENTS WILL NOT BE GIVEN UNTIL PROOF OF MENINGITIS IMMUNIZATION IS PROVIDED!

C. Documentation of other immunizations received prior to entry at Montclair State University (NOT REQUIRED):

Td ___/___/___ (M D Y) **Tdap ___/___/___** (M D Y) **Polio (IPV) Dose #1 __/__/__** (M D Y) **Dose #2 __/__/__** (M D Y) **Dose #3 __/__/__** (M D Y) **Booster __/__/__** (M D Y)

Varicella Dose # 1___/___/___ (M D Y) **Dose # 2 __/__/__** (M D Y) **Documented disease ___/___/___** (M D Y) **Titer ___/___/___** (M D Y)

Hepatitis A: Dose #1 ___/___/___ (M D Y) **Dose #2 ___/___/___** (M D Y) **Titer __/__/__** (M D Y)

Pneumonia ___/___/___ (M D Y) **Typhoid ___/___/___** (M D Y) **Influenza ___/___/___** (M D Y)

HPV Dose #1 ___/___/___ (M D Y) **Dose #2 ___/___/___** (M D Y) **Dose # 3 ___/___/___** (M D Y)

PPD (Mantoux): Date _____/_____/_____ (M D Y) **Reaction ______ Neg ______Pos ________________mm**

Chest X-ray: Date: _____/_____/_____ (M D Y) **Result: ____**

INH Therapy Start Date: _____/_____/______ (M D Y) **Stop Date: ____/____/____** (M D Y)

_____________________________________ __________________ _____________________

Signature of Health Care Provider **Date** **Provider Stamp**

KEEP A COPY OF THIS DOCUMENTATION FOR YOUR RECORDS!

THIS SECTION TO BE COMPLETED BY ALL STUDENTS

Name ___________________________________SS#____ -____ - ____ CWID# ____________________

New Jersey statutes require that all students be informed about meningitis disease, the effectiveness of the vaccines and the availability of immunization. This information can be obtained by accessing www.montclair.edu and accessing the University Health Center website. Vaccine for meningococcal meningitis disease can be obtained through your private health care provider or at the University Health Center. After accessing this information please complete the following questionnaire and submit with immunization documentation:

I have reviewed the information on meningitis and intend to receive the vaccine _______

I have reviewed the information on meningitis and choose to not receive the vaccine _______

I have reviewed the information on meningitis and will receive the vaccine as a requirement for University housing _______

____ ____________________

Student Signature **Date**

DO NOT DOCUMENT PROOF OF VACCINATION FOR MENINGITIS ON THIS FORM

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN OF ALL STUDENTS UNDER AGE 18

Consent for medical treatment for students under age 18:

I hereby authorize the University Health Center at Montclair State University to render any treatment or medical, surgical, or psychological care deemed necessary to the health and safety of ___________________________________ and to facilitate ambulance transport to a nearby hospital in the case of a medical emergency.

Date__________________

Student Name __________________________Parent/Guardian Name____________________________

Student Social Security Number ________________ Student CWID Number______________________

Parent/Guardian Signature____

Emergency Contact Information:

Name __________________________________ Relationship________________________

Daytime Telephone ______________________ Evening Telephone__________________

Cell Phone Number ___________________