MONTCLAIR STATE STUDENT HEALTH CENTER

INTERNATIONAL STUDENT IMMUNIZATION VERIFICATION FORM (updated 5/21/24)

STUDENT NAME (Last, first): _____ **Date of birth**: _____

CWID: _____

INSTRUCTIONS: Your healthcare provider must complete, sign and stamp this form. It will become your reference & verification document. The MyHealth portal cannot read images. You must also type the dates into the portal's online immunization form. Scan & upload documents into the portal. Blood test results (titers) are accepted in lieu of immunization dates.

MMR REQUIREMENT (Full-time and Part-time students) - Measles-Mumps-Rubella (MMR)
MMR dose 1st date: _____ (date must be after first birthday)
MMR dose 2nd date : _____

-OR-

Individual Measles, Mumps, and Rubella Vaccines:
Measles 1st dose: _____ (date must be after first birthday)
Measles 2nd dose: _____
Mumps 1st dose: _____ (date must be after first birthday)
Mumps 2nd dose: _____
Rubella Single dose: _____ (date must be after first birthday)

-OR-

MMR Titers (Lab results must be positive or negative. Equivocal results not accepted.)
Measles lab date: _____ Result (circle one): POSITIVE NEGATIVE
Mumps lab date: _____ Result (circle one): POSITIVE NEGATIVE
Rubella lab date: _____ Result (circle one): POSITIVE NEGATIVE

HEPATITIS B REQUIREMENT: (Full-time students)
Date for dose 1: _____ Date for dose 2: _____ Date for dose 3: _____
Dose 2 = 4 wks after dose 1. Dose 3 = 16 wks after dose 1 + 8 wks after dose 2.

-OR-

HepB Titers: date _____ Result (circle one): POSITIVE NEGATIVE

MENINGITIS REQUIREMENT (SeroGroup ACWY):
Students under 19yrs (Commuter & Resident, 2 doses w/2nd dose given after 16th birthday)
Dose 1 ___ __ Dose 2__ _____
Students 19yrs + older (Resident, 1 Dose after 16th b'day + w/in last 5yrs) Date: _____

STUDENT NAME (Last, first): _____ **Date of birth**: _____

CWID: _____

STRONGLY RECOMMENDED (Not required)

COVID-19 (Residential students) Manufacturer name: _____

Dose 1 _____ Dose 2_____ Add'l doses _____

Meningococcal B Vaccine: Serogroup B - Bexsero
Date for dose 1: _____ Date for dose 2: _____

Meningococcal B Vaccine: Serogroup B - Trumenba (2 or 3 dose schedule)
Date for dose 1: _____ Date for dose 2: _____ Date for dose 3: _____

Varicella (Chickenpox) Vaccine:
Date of dose 1: _____ Date of dose 2: _____

Tdap (tetanus, diphtheria and pertussis) Vaccine (this is not the same as DTap):
Date of last Tdap dose: _____

Td (tetanus, diphtheria) Vaccine:
Date of last Td dose: _____

Hepatitis A (Hep A) Vaccine:
Date of dose 1: _____ Date of dose 2: _____

Human Papilloma (HPV) Vaccine: Manufacturer name: _____
Date of dose 1: _____ Date of dose 2: _____ Date of dose 3: _____

Pneumococcal Vaccine 13-Valent: Pneumococcal Vaccine 23-Valent:
Date of dose 1: _____ Date of dose 1: _____

TST/PPD (Mantoux): Date: _____ Reaction: _____ Negative _____Positive
_____Induration _____mm

Chest X-ray: Date: _____ Result: _____
INH Therapy Start Date: _____ Stop Date: _____

HEALTHCARE PROVIDER

Name: _____ Title: _____
Stamp: