### MONTCLAIR STATE UNIVERSITY HEALTH CENTER
### IMMUNIZATION VERIFICATION FORM

<table>
<thead>
<tr>
<th>PRINT STUDENT NAME (LAST, FIRST, MI)</th>
<th>DATE OF BIRTH (MM/DD/YYYY)</th>
<th>CWID</th>
</tr>
</thead>
</table>

**GENERAL INSTRUCTIONS:** This form must be completed, stamped and signed by your healthcare provider and then scanned and uploaded after entering vaccine information on the immunization form of the MyHealth web portal.

*FOR THE SAFETY OF OUR CAMPUS COMMUNITY, STUDENTS WHO DO NOT PROVIDE APPROPRIATE EVIDENCE OF IMMUNITY MAY BE REMOVED FROM CAMPUS DURING A COMMUNICABLE DISEASE OUTBREAK.*

**HEALTHCARE PROVIDER INSTRUCTIONS:** Please complete this form and provide a copy of any antibody titer blood test results that demonstrate immunity to specific diseases if laboratory testing was done.

#### MMR REQUIREMENT:
*(ALL DEGREE SEEKING STUDENTS)* 2 doses Measles (Rubeola), 2 doses Mumps and 1 dose Rubella after first birthday or 2 doses MMR after first birthday or Positive (reactive) MMR titers confirming immunity. Dose 2 of all vaccines must be given at least 4 weeks after dose 1.

**Measles-Mumps-Rubella (MMR) Vaccine:**
- OR -
**Individual Measles, Mumps, Rubella Vaccine:**

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Date for dose 1</th>
<th>Date for dose 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MMR TITERS** (Equivocal results are not accepted. Results must be POSITIVE or NEGATIVE and accompanied by a copy of blood test results. Please note that ONLY positive (reactive) titers satisfy the requirement.)

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Date</th>
<th>Result (circle one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td>POSITIVE</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td>POSITIVE</td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td>POSITIVE</td>
</tr>
</tbody>
</table>

#### HEPATITIS B REQUIREMENT:
*(ALL FULL-TIME, DEGREE SEEKING STUDENTS)*

<table>
<thead>
<tr>
<th>Date for dose 1</th>
<th>Date for dose 2</th>
<th>Date for dose 3</th>
</tr>
</thead>
</table>

Dose 2 must be at least 4 weeks after dose 1. Dose 3 must be at least 16 weeks after dose 1 and 8 weeks after dose 2.

#### MENINGITIS REQUIREMENT:
*(ALL STUDENTS RESIDING IN UNIVERSITY HOUSING ONLY)*. One dose of MCV4 – Meningococcal conjugate serogroups A, C, W and Y on or after 16th birthday is required for students living in University Housing. Common U.S. names for this vaccine are Menveo and Menactra.

<table>
<thead>
<tr>
<th>Date of Meningococcal (MCV4) Vaccine</th>
<th>#1</th>
<th>#2</th>
</tr>
</thead>
</table>

The following vaccinations are strongly recommended:

**BEXSERO Meningococcal B Vaccine: Serogroup B**

- OR –

**TRUMENBA Meningococcal B Vaccine: Serogroup B** *(Can be given in a 2 or 3 dose schedule)*

**These vaccines ARE NOT required for University Housing.**
### PRINT STUDENT NAME (LAST, FIRST, MI)  DATE OF BIRTH (MM/DD/YYYY)  CWID

Varicella (Chickenpox) Vaccine:
- Date of dose 1: __________
- Date of dose 2: __________
- OR –
Varicella (Chickenpox) Titer – If you have had chickenpox, an antibody titer test can be performed to confirm immunity to the disease. Results must be accompanied by a copy of the blood test results. ONLY Positive titers confirm immunity.
- Date of Varicella Titer: __________
- Result (circle one): POSITIVE  NEGATIVE

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: __________

CERVARIX Human Papilloma (HPV) Vaccine:
- Date of dose 1: __________
- Date of dose 2: __________
- Date of dose 3: __________

GARDASIL Human Papilloma (HPV) Vaccine:
- Date of dose 1: __________
- Date of dose 2: __________
- Date of dose 3: __________

GARDASIL-9 HUMAN PAPILLOMA (HPV) VACCINE:
- Date of dose 1: __________
- Date of dose 2: __________
- Date of dose 3: __________

Pneumococcal Vaccine 13-Valent:
- Date of dose 1: __________

Pneumococcal Vaccine 23-Valent:
- 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 (please print)

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Phone:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Organizational Stamp:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provider: Please provide completed form and copy of antibody titer blood tests.