

MONTCLAIR STATE UNIVERSITY HEALTH CENTER

IMMUNIZATION VERIFICATION FORM

PRINT STUDENT NAME (LAST, FIRST, MI)

DATE OF BIRTH (MM/DD/YYYY)

CWID

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:

Date for MMR dose 1: (must be after first birthday) _____ Date for MMR dose 2: _____

-OR-

Individual Measles, Mumps, Rubella Vaccine:

Date for Measles dose 1: (must be after first birthday) _____ Date for Measles dose 2: _____

Date for Mumps dose 1: (must be after first birthday) _____ Date for Mumps dose 2: _____

Date for Rubella dose 1: (must be after first birthday) _____

-OR-

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.)

Date for Measles titer confirming immunity: _____ Result (circle one): POSITIVE NEGATIVE

Date for Mumps titer confirming immunity: _____ Result (circle one): POSITIVE NEGATIVE

Date for Rubella titer confirming immunity: _____ Result (circle one): POSITIVE NEGATIVE

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

Date for dose 1: _____ Date for dose 2: _____ Date for dose 3: _____

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.**

Date of Meningococcal (MCV4) Vaccine: #1 _____ #2 _____

The following vaccinations are strongly recommended:

****BEXSERO Meningococcal B Vaccine: Serogroup B**

Date for dose 1: _____ Date for dose 2: _____

- OR -

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

Date for dose 1: _____ Date for dose 2: _____ Date for dose 3: _____

**** 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 PAPILOMA (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)		Title:
Signature:	Phone:	Date:
Address:	Organizational Stamp:	
Provider: Please provide completed form and copy of antibody titer blood tests.		