# 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:**

<table>
<thead>
<tr>
<th>Date for MMR dose 1: (must be after first birthday)</th>
<th>Date for MMR dose 2:</th>
</tr>
</thead>
</table>

-OR-

**Individual Measles, Mumps, Rubella Vaccine:**

<table>
<thead>
<tr>
<th>Date for Measles dose 1: (must be after first birthday)</th>
<th>Date for Measles dose 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date for Mumps dose 1: (must be after first birthday)</td>
<td>Date for Mumps dose 2:</td>
</tr>
<tr>
<td>Date for Rubella dose 1: (must be after first birthday)</td>
<td>Date for Rubella dose 2:</td>
</tr>
</tbody>
</table>

-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.)*

<table>
<thead>
<tr>
<th>Date for Measles titer confirming immunity:</th>
<th>Date for Mumps titer confirming immunity:</th>
<th>Date for Rubella titer confirming immunity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date for Measles dose 1:</td>
<td>Date for Mumps dose 1:</td>
<td>Date for Rubella dose 1:</td>
</tr>
<tr>
<td>Date for Measles dose 2:</td>
<td>Date for Mumps dose 2:</td>
<td>Date for Rubella dose 2:</td>
</tr>
<tr>
<td>Result (circle one): POSITIVE</td>
<td>Result (circle one): POSITIVE</td>
<td>Result (circle one): POSITIVE</td>
</tr>
<tr>
<td>NEGATIVE</td>
<td>NEGATIVE</td>
<td>NEGATIVE</td>
</tr>
</tbody>
</table>

### 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.)*

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**

-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.**
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: __________   Date of dose 2: __________

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)

Signature:  Phone:  Date:

Address:  Organizational Stamp:

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