MONTCLAIR STATE UNIVERSITY HEALTH CENTER

IMMUNIZATION VERIFICATION FORM

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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.

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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

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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.

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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 _____________

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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 PAPILLLOMA (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.		