Student Health Center
MONTCLAIR STATE UNIVERSITY

1 Normal Ave. Montclair, NJ 07043 | Blanton Hall
Phone: (973) 655-4361 | Email: askanurse@montclair.edu
Submit this form to: ***montc.studenthealthportal.com***

Immunization History Form

Student's Name: **Date of Birth:**

CWID: **Student Cell Phone #**

REQUIRED - Measles, Mumps, Rubella

MMR *(2-dose series):*

Dose 1: ____/____/____
(Must be on or after 1st birthday)

Dose 2: ____/____/____

OR

Measles:

1: ___/___/___ 2: ___/___ / ___

Mumps:

1: ___/___/___ 2: ___/___/___

Rubella : ____/___/___

OR

MMR Antibodies (IgG) (within 10 years

Result Date: ____/____/____

A copy of the lab report is REQUIRED.

If non-immune, the state requires you to receive the appropriate vaccination(s).

REQUIRED for full time- Hepatitis B

Hepatitis B (3-dose series):

Dose 1: ____/____/____
Dose 2: ____/____/____
Dose 3: ____/____/____
Dose 4: ____/____/____

OR

Hepatitis B (2-dose series):

Dose 1: ____/____/____

Dose 2: ____/____/____

OR

Hepatitis B Surface Antibody (HBsAb)

(within 10 years) Result Date: ____/ ____/ ____

A copy of the lab report is REQUIRED.

If non-immune, the state requires you to receive the appropriate vaccination(s).

REQUIRED - Meningococcal-ACYW

Dose 1: ___ /___ /___ Dose 2: ___ /___ /___

ONE *dose must be given at age* ***16 or older*** *AND IF you're a new residential student, your last dose must be within 5 years.*

Meningococcal-B REQUIRED *for at risk individuals*

(including asplenia, sickle cell, complement deficiency or complement inhibitor use, HIV or N. meningitidis lab work)

Dose 1: ___ /___ /___ Dose 2: ___ /___ /___ Dose 3: ___ /___ /___ ☐ **Bexsero** ☐ **Trumenba**

TB Testing REQUIRED for All International Students

PPD (Mantoux) Skin Test *(within 6 months)*

Administer Date: ____/ ____ /____

Result Date: ____/ ___/ ____

Negative ☐ Positive ☐ Induration (mm): _____

OR

QFT-G or T-Spot results are accepted

A copy of the lab report is REQUIRED

** A positive result requires a recent chest x-ray.*

		HPV	Hepatitis A	Varicella	Tdap
Recommended Vaccines	1				
	2				
	3				

Healthcare Provider Name (please print):

_____

Signature: _____

Date:

Healthcare Provider Stamp