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 NEW STUDENTS < 19 years of age. Two doses of MCV4 – Meningococcal conjugate serogroups A, C, W and Y. One dose must be given on or after 16th birthday. Students > 19 years old RESIDING IN CAMPUS HOUSING or with increased risk factors, are also required to have the MCV4 vaccine on or after 16th birthday. Students 16 – 18 years of age who have never been vaccinated for Meningococcal Meningitis are required to have one dose of MCV4.
Common U.S. names for this vaccine are Menveo and Menactra.
Dates of Meningococcal (MCV4) Vaccine: #1  __________  #2  __________
The following vaccinations are strongly recommended:
** These vaccines ARE NOT required for University Housing.

**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:  __________

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The following vaccinations are recommended:

**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:**  **Pneumococcal Vaccine 23-Valent:**
- Date of dose 1: __________  Date of dose 1: __________

**TST/PPD (Mantoux):**
- Date: __________  Reaction: _____ Negative  _____ Positive  _____ Induration _____mm
  - Chest X-ray:  Date: __________  Result: _______________________
  - INH Therapy  Start Date: __________  Stop Date: __________

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**HEALTHCARE PROVIDER NAME (please print)**

**Signature:**  **Phone:**  **Date:**

**Address:**

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