NJIT – NEW JERSEY INSTITUTE OF TECHNOLOGY
PRE-ENTRANCE IMMUNIZATION RECORD

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

Date of Birth: _____ NJIT ID #: _____ Full-Time ☐ Part-Time ☐

STUDENT SIGNATURE (REQUIRED): _____

FORM MUST BE SIGNED AND RETURNED TO:

New Jersey Institute of Technology
Dean of Students and Campus Life, 255 Campus Center
University Heights, Newark, NJ 07102
Website: www.njit.edu/healthservices, Email: healthservices@njit.edu
Office #973-596-3621, Fax #973-388-2173

VACCINE	Dose #1 Date	Dose #2 Date	Dose #3 Date	Date of positive Immune Titer
MMR (Measles, Mumps, Rubella) 2 Doses required ON OR AFTER 12 months of age. The second MMR vaccine must be 30 days after the first vaccine. MMR requirement is only for those born in 1957 or later. **OR** (Attach lab report showing serology blood test **IgG levels** for MMR).				
OR				
MEASLES (Rubeola) 2 Doses REQUIRED				
MUMPS 2 Doses REQUIRED				
RUBELLA (German Measles) 2 Doses REQUIRED				
MENINGOCOCCAL MENINGITIS (for all students) - 1st dose prior to age 16 an *additional dose* should be given before the start of College. ☐ Menactra ☐ Menveo (please check one) REQUIRED for all students attending NJIT				
TB SKIN TESTING –(within 6 month of Admission) A recent TB Test is needed and is **Required** for **All** students. If positive TB skin test, do not Repeat. Please record the date of Positive result and chest x-ray information below.) May use QuantiFERON Test.	**Date Given** _____ **Date Read** _____	**Positive** ☐	**Negative** ☐	**Result** _____MM
A. If positive TB test: Must submit a x-ray report, treatment date, if applicable QuantiFERON Gold blood test.	**X-ray Date**	**Normal** ☐	**Abnormal** ☐	**Treatment Date**
HEPATITIS B - Required 3 doses for all students. **OR** Attach lab report showing evidence of immunity. **(Hep. B Antibody)**				
Tdap (within last 10 years) required				
TD (within last 10 years) required				
Varicella (Chickenpox) required 2 doses of vaccines **OR** blood work showing a positive **IgG antibody titer** (Attach report)				

Healthcare Provider Name, Address, and Signature (Required): Include Phone and Fax

Name: _____ **Signature:** _____ **Date** _____

Address: _____ **Phone:** _____ Fax: _____