IMMUNIZATION RECORD**

**This form is required for ALL students

NJIT Student I. D number (8 digit): _____________________________

Last Name                      First Name                      Middle Initial

Street Address Telephone

City                        State                        Country

Zip Code

First Enrolled (Mo/Yr)        Date of Birth

M / F

PART A: MEASLES, MUMPS, RUBELLA IMMUNIZATION Required 2 doses:

FIRST MMR date               SECOND MMR date

On /after first birthday     2nd shot must be 30 days after 1st shot

PART B: (To be filled out ONLY if you have not filled out PART A)

MEASLES #1 date              MUMPS #1 date

On/after 1st birthday        On/after 1st birthday

RUBELLA date

On/after 1st birthday

MEASLES #2 date

30 days after 1st shot

MUMPS #2 date

30 days after 1st shot

Rubella #2 date

30 days after 1st shot

OR Submit blood titers for Measles, Mumps and Rubella. *Blood Titers must be accompanied by a lab report indicating a numerical value for the titer IgG level and a reference range.

BLOOD TITERS* date

*please attach lab report

PART C: HEPATITIS B REQUIRED – Required 3 doses for all students OR submit blood titers for Hepatitis B surface antibody and provide the lab report

Hepatitis B 1st Date

2nd Date

3rd Date
PART D: MENINGITIS REQUIRED FOR ALL STUDENTS

Meningococcal Meningitis (Menveo or Menactra)

1st dose prior to age 16 an additional dose should be given before the start of College

MENINGITIS VACCINE date(s):

Initial Booster

It is also required that all students submit evidence of Meningitis B regardless of age or residential status.

MENINGOCOCCAL B: ____________ ____________ Circle: 2 dose or 3 dose series

(Men B vaccine) Circle: Trumenba/Bexsero

Dose #2 Circle: 30 days after 1st dose/6 months after 1st dose

PART E: It is required that all students have a TB test before entering the college.

MANTOUX (PPD): Must be done within 6 months prior to arrival on campus.

Date Placed ____________ Date Read ____________ *Results ____________

*Positive test results require proof of Chest X-ray. *Indicate mm of induration

Or submit the Quantiferon Gold blood test attach lab report

PART F: OTHER IMMUNIZATIONS STRONGLY RECOMMENDED BUT NOT REQUIRED

Tdap Date: ____________ OR Tetanus Date: ____________

Varicella #1 Date: ____________ Varicella #2 Date ____________ OR Provide a Lab Report(showing a positive IgG antibody titer)

PART G: Covid-19

Covid Testing results

Positive ____________ Negative ____________ Date of Test ____________

Type of Test _______________________________________

Physician Signature/Stamp: ____________________________ Date: ______________________

Address: __________________________________________ Phone #: ____________________