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  Gender

PART A: MEASLES, MUMPS, RUBELLA IMMUNIZATION:

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  RUBELLA date

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

MEASLES #2 date  MUMPS #2 date  Rubella #2 date

30 days after 1st shot  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 Menectra)

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

MENINGITIS VACCINE date(s):

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

MENINGITIS B: 2 dose or 3 dose series

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

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 #: ___________________________