

STUDENT NAME _____

STEVENS ID (8-Digit) _____



STUDENT HEALTH & IMMUNIZATION RECORD

STUDENT HEALTH SERVICES . CASTLE POINT ON HUDSON . HOBOKEN, NJ 07030 .T: 201-216-5678 . F: 201-216-5677

THIS SECTION MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER OR A COPY OF YOUR IMMUNIZATION RECORDS MUST BE PROVIDED.

If documentation of vaccines is unavailable, an immune titer blood test is required (please include actual copy of results). If the titer does not indicate immunity (including equivocal immunity), vaccines are required.

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| <p>MEASLES, MUMPS, RUBELLA (MMR): REQUIRED for ALL Students</p> <ul style="list-style-type: none"> 2 doses of vaccine administered, on or after 12 months of age, and at least 28 days apart are required, OR Laboratory proof of immunity; copy of Measles (Rubeola), Mumps, and Rubella Virus IgG Antibody laboratory titer report MUST be provided if submitting in lieu of immunization dates. <i>EQUIVOCAL or ANTIGEN RESULTS NOT ACCEPTABLE.</i> | | | |
| <p>MMR Dose 1: ____/____/____ M D Y</p> <p>MMR Dose 2: ____/____/____ M D Y</p> | OR | <p>MEASLES, MUMPS AND RUBELLA IgG Titer Lab Report Showing positive immunity.</p> | OR |
| | | | <p>MEASLES :1: ____/____/____ 2: ____/____/____ M D Y</p> <p>MUMPS : 1: ____/____/____ 2: ____/____/____ M D Y</p> <p>RUBELLA : 1: ____/____/____ 2: ____/____/____ M D Y</p> |

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| <p>HEPATITIS B – REQUIRED for ALL Students (a copy of a Hepatitis B IgG Surface Antibody (anti-HBc) laboratory titer report MUST be provided if submitting in lieu of immunization dates. <i>EQUIVOCAL or ANTIGEN RESULTS NOT ACCEPTABLE.</i>)</p> | | |
| <p>HEPATITIS B vaccine</p> <p>Dose 1: ____/____/____</p> <p>Dose 2: ____/____/____</p> <p>Dose 3: ____/____/____ M D Y</p> | <p>HEPATITIS A and B combined</p> <p>Dose 1: ____/____/____</p> <p>Dose 2: ____/____/____</p> <p>Dose 3: ____/____/____ M D Y</p> | <p>Must provide HEPATITIS B IgG Titer Lab Report showing positive immunity.</p> |

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| VARICELLA (Chicken Pox)- REQUIRED for UNDERGRADUATE STUDENTS ONLY | | | |
|--|-----------|---|--|
| 2 doses of VARICELLA VACCINE REQUIRED Dose # 1: ___/___/___ Dose #2: ___/___/___ M D Y | OR | Laboratory Documentation of Immunity Varicella Zoster Virus (VZV) IgG ANTIBODY test only (IgM NOT Accepted) Copy of Laboratory report must be provided. | History of Chicken Pox? Infection or history of herpes zoster, based on health care provider diagnosis Date: ___ / ___ / ___ M Y |

Meningococcal Meningitis – Required for UNDERGRADUATE STUDENTS ONLY

BOOSTER DOSE may be required if administered more than 5 years prior to the start date of classes. If the initial dose was administered before the 16th birthday, a booster dose should be administered after the 16th birthday. The minimum interval between doses of the meningococcal conjugate vaccine is 8 weeks.

| <u>MENINGOCOCCAL A, C, W, Y</u> (Menactra or Menveo) | <u>MENINGOCOCCAL B</u> | |
|--|---|---|
| Dose # 1: ___/___/___ Dose #2: ___/___/___ | <u>Bexsero</u> Dose # 1: ___/___/___ Dose #2: ___/___/___ | <u>Trumenba</u> Dose # 1: ___/___/___ Dose #2: ___/___/___ Dose #3 : ___/___/___ |

The following are recommended, not required

| | | | |
|---|--|--|---|
| Hepatitis A 1: ___/___/___ 2: ___/___/___ M D Y | HPV Dose 1: ___/___/___ Dose 2: ___/___/___ Dose 3: ___/___/___ M D Y | Influenza ___/___/___ M D Y | COVID-19 Dose 1: ___/___/___ Dose 2: ___/___/___ Dose 3: ___/___/___ M D Y |
|---|--|--|---|

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| TETANUS, DIPHTHERIA, PERTUSSIS Recommended vaccination (Tdap), not required |
| TETANUS – Booster in the last 10 years. |

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| Tdap Dose: ____ / ____ / ____ M D Y | or | TD Dose: ____ / ____ / ____ M D Y |
|--|-----------|--|

Required for international students

**** Interferon-based Assay TB Blood Test QuantiFERON Gold/T-spot (preferred) or PPD Mantoux:**
(Must be performed within last 6 months, PPD not recommended for those with a history of taking BCG)

Result _____ (provide copy of laboratory report)

Test Date _____ Date Read: _____ Date: Results: _____mm

Copy of chest x-ray written report required if: PPD is ≥ 10 mm. induration (horizontal diameter) OR if Interferon-based Assay Blood Test is Positive

****DO NOT SEND US DIGITAL IMAGE OF CHEST XRAY, WRITTEN REPORT ONLY INH**

Therapy taken? Yes No_(If yes, please provide documentation).

Prior PPD history: Date: _____ Results: _____mm

**** Required by Stevens Institute of Technology OR WITHOUT SIGNATURE, OFFICE STAMP AND THE REQUIRED INFORMATION WILL BE CONSIDERED INCOMPLETE**

Signature of Health Care Provider

Print Name _____

Address

Ph # _____

Fax # _____

Office Stamp _____

Date

Where can you obtain an acceptable record of your immunizations? Students are responsible for contacting the various agencies or institutions and for requesting a copy of their immunization records.

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ALL RECORDS MUST BE IN ENGLISH OR ACCOMPANIED BY A TRANSLATION.

1. High School or Previous Colleges: A copy of the immunization record may be obtained from your high school, Board of Education, or a previously attended college. These records may contain adequate information.
2. Personal Immunization Record: Records from pediatricians or family medical providers are acceptable, if verified (with stamp or signature), and contain proof of minimum requirements.
3. Local Health Department: If primary immunizations were received at a local health department, a copy may be obtained from this source.