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.**

MEASLES, MUMPS, RUBELLA (MMR): REQUIRED for ALL Students

- 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; **c**opy of Measles (Rubeola), Mumps, and Rubella Virus IgG Antibody laboratory titer report MUST be provided if submitting in lieu of immunization dates. *EQUIVOCAL or ANTIGEN RESULTS NOT ACCEPTABLE*.

MMR Dose 1: ____/____/___ M D Y **MMR Dose 2:**____/___/____ M D Y	**OR**	**MEASLES, MUMPS AND RUBELLA IgG Titer Lab Report Showing positive immunity.**	**OR**	**MEASLES :**1: _____/____/___ 2: _____/___ /____ M D Y **MUMPS :** 1: _____/____/___ 2: ____/_____/___ M D Y **RUBELLA :** 1: _____/____/___ 2: ____/_____/___ M D Y

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. *EQUIVOCAL or ANTIGEN RESULTS NOT ACCEPTABLE*.)

HEPATITIS B vaccine	**HEPATITIS A and B combined**	
Dose 1: _____/___/___	Dose 1: ____/___/___	**Must provide HEPATITIS B IgG Titer Lab Report showing positive immunity.**
Dose 2: _____/___/____	Dose 2: _____/___/____	
Dose 3: _____/___/____ M D Y	Dose 3: _____/___/____ M D Y	

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Meningococcal Meningitis – REQUIRED FOR UNDERGRADUATE STUDENTS ONLY

The Meningococcal ACWY vaccine DOES NOT cover Meningococcal B. These are separate vaccines for separate strains of Meningitis. Both vaccines are required.

Penbraya and Penmenvy are currently the only combination vaccines available. Due to them only recently being introduced, they are not commonly given; however, they are acceptable.

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.

MENINGOCOCCAL A, C, W, Y (Menactra or Menveo)	MENINGOCOCCAL B		MEN ABCWY
	Bexsero	Trumenba	Penbraya or Penmenvy
Dose #1: ____/_____/_____ Dose #2: ____/_____/_____	Dose # 1: ____/_____/_____ Dose #2: ____/_____/_____	Dose #1: ____/_____/_____ Dose #2: ____/_____/_____ Dose #3 : ____/_____/_____	Dose #1: ____/_____/_____

The following are recommended, not required:

Hepatitis A	HPV	Influenza	COVID-19	Varicella (Chicken Pox)
1: _____/_____/_____ 2: ____/_____/_____ M D Y	Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____ M D Y	_____/____/_____ M D Y	Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____ Dose 4: _____/_____/_____ Dose 5: _____/_____/_____ M D Y	Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ **Or** **History of Chicken Pox?** Infection or history of herpes zoster, based on health care provider diagnosis Date: ____/____/_____ M D Y

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 ≥ 10mm. 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.