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

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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 of classes.** 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 meningococcal conjugate vaccine is 8 weeks.		
	MENINGOCOCCAL B	
MENINGOCOCCAL A, C, Y,W- **(Menactra or Menveo)** Dose # 1: _____/_____/_____ Dose #2: ____/_____/______	**Bexsero** 1: / / 2: / / M D Y	**Trumemba** 1: / / 2: / / 3: / / M D Y

Covid- 19 -Recommended for all students a copy of CDC card or equivalent documentation also accepted, please upload all Covid-19 vaccinations. *ANTIBODY RESULTS NOT ACCEPTABLE*.	
Dose: _____/______/____ Manufacturer ________ M. D Y Dose: ______/____/____ Manufacturer ________ M. D Y Dose: ______/____/____ Manufacturer ________ M. D Y	Dose: _______/_______/____ Manufacturer ________ M. D Y Dose: _______/_______/____ Manufacturer ________ M. D Y

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The following are recommended, not required

Hepatitis A	**HPV**	**Pneumococcal**	**Influenza**
1: _____/_____/_____ 2: _____/_____/______ M D Y	Dose 1:______/_____/_____ Dose 2:______/_____/_____ Dose 3:______/______/_____ M D Y	_____/____/_______ M D Y	_____/____/_______ M D Y

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

STUDENT NAME ____________________

STEVENS ID (8-Digit) ____________________

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.

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.