STUDENT NAME _____

STEVENS ID (8-Digit) _____



STUDENT HEALTH & IMMUNIZATION RECORD

STUDENT HEALTH SERVICES 1 CASTLE POINT TERRACE, 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 30 years old or younger

- 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: _____/_____/_____ **MMR Dose 2: _____/_____/_____** **M D Y**	**OR**	**MEASLES, MUMPS AND RUBELLA IgG Titer Lab Report Showing positive immunity.**	**OR**	**Measles Dose 1: _____/_____/_____** **Measles Dose 2: _____/_____/_____** **M D Y** **Mumps Dose 1: _____/_____/_____** **Mumps Dose 2: _____/_____/_____** **M D Y** **Rubella Dose 1: _____/_____/_____** **Rubella Dose 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 # 1: ____/_____/_____	Dose #1: ____/_____/_____	Dose #1: ____/_____/_____
Dose #2: ____/_____/_____	Dose #2: ____/_____/_____	Dose #2: ____/_____/_____	M D Y
M D Y	M D Y	Dose #3: ____/_____/_____	
		M D Y	

The following are required: *Healthcare provider documentation of a completed primary series for polio, DTaP/Td/Tdap, and Varicella for international students would be acceptable (even if dates are not available).

Polio IPV	Td/Tdap/DTaP		Varicella (Chicken Pox)
	DTap:	Td/Tdap	
(OPV doses are only acceptable if given before April 1, 2016. Doses given after April 1, 2016 must receive IPV doses instead.)	Dose 1: _____/_____/_____	Dose 1: _____/_____/_____	Dose 1: _____/_____/_____
	Dose 2: _____/_____/_____	Dose 2: _____/_____/_____	Dose 2: _____/_____/_____
Dose 1: _____/_____/_____	Dose 3: _____/_____/_____	M D Y	Or
Dose 2: _____/_____/_____	Dose 4: _____/_____/_____		**History of Chicken Pox?** Infection or history of herpes zoster, based on health care provider diagnosis
Dose 3: _____/_____/_____	Dose 5: _____/_____/_____		Date: ____/_____/_____
M D Y	M D Y		M D Y

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The following are recommended, not required:

Hepatitis A	**HPV**	**Influenza**	**COVID-19**
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: _____/_____/_____

TB Testing: Required for international students. All testing must be within 6 months of student's start date. PPD not recommended for those with a history of taking BCG) If therapy has been taken, please upload documentation.		
PPD **Test Date:**_____/_____/_____ **Date Read:**_____/_____/_____ **Result** _____ **Induration:**_____**mm** *If results are positive, please read Chest X-Ray requirement.*	**** Interferon-based Assay TB Blood Test QuantiFERON Gold/T-spot (preferred)**** Lab report must be submitted in order for this requirement to be met. We cannot accept written positive/negative results. *If results are positive, please read Chest X-Ray requirement.*	**Chest X-Ray** Chest X-Ray is required if PPD IS ≥ 10mm induration (horizontal diameter OR if Interferon-based Assay Blood test is positive. X-Ray report must be submitted in order for this requirement to be met. We cannot accept written positive/negative results. We also do not accept digital X-Ray images.

**** Health Care Provider's signature AND stamp are both required. Without these, the form will be considered incomplete and will not be accepted.****

Health Care Provider's Name: _____

Provider's Office Address: _____

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Provider's Office Phone Number: _____ Provider's Office Fax Number: _____

Provider's Signature: _____ Provider's Office Stamp: _____

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.