**MONTCLAIR STATE STUDENT HEALTH CENTER**

**INTERNATIONAL STUDENT IMMUNIZATION VERIFICATION FORM (updated 5/21/24)**

**STUDENT NAME** (Last, first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CWID**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**INSTRUCTIONS:** Your healthcare provider must complete, sign and stamp this form. It will become your reference & verification document. The MyHealth portal cannot read images. You must also type the dates into the portal’s online immunization form. Scan & upload documents into the portal. Blood test results (titers) are accepted in lieu of immunization dates.

**MMR REQUIREMENT (Full-time and Part-time students)** - Measles-Mumps-Rubella (MMR)

MMR dose 1st date: \_\_\_\_\_\_\_\_\_\_\_ (date must be after first birthday)

MMR dose 2nd date : \_\_\_\_\_\_\_\_\_\_\_

**-OR-**

Individual Measles, Mumps, and Rubella Vaccines:

Measles 1st dose: \_\_\_\_\_\_\_\_\_\_ (date must be after first birthday)

Measles 2nd dose: \_\_\_\_\_\_\_\_\_

Mumps 1st dose: \_\_\_\_\_\_\_\_\_\_ (date must be after first birthday)

Mumps 2nd dose: \_\_\_\_\_\_\_\_\_

Rubella Single dose: \_\_\_\_\_\_\_\_\_\_ (date must be after first birthday)

**-OR-**

MMR Titers (Lab results must be positive or negative. Equivocal results not accepted.)

Measles lab date: \_\_\_\_\_\_\_\_\_\_ Result (circle one): POSITIVE NEGATIVE

Mumps lab date: \_\_\_\_\_\_\_\_\_\_ Result (circle one): POSITIVE NEGATIVE

Rubella lab date: \_\_\_\_\_\_\_\_\_ Result (circle one): POSITIVE NEGATIVE

**HEPATITIS B REQUIREMENT: (Full-time students**)

Date for dose 1: \_\_\_\_\_\_\_\_\_\_ Date for dose 2: \_\_\_\_\_\_\_\_\_\_ Date for dose 3: \_\_\_\_\_\_\_\_\_\_

Dose 2 = 4 wks after dose 1. Dose 3 = 16 wks after dose 1 + 8 wks after dose 2.

**-OR-**

HepB Titers: date \_\_\_\_\_\_\_\_\_\_\_\_\_ Result (circle one): POSITIVE NEGATIVE

**MENINGITIS REQUIREMENT (SeroGroup ACWY)**:

**Students** **under 19yrs** (Commuter & Resident, 2 doses w/2nd dose given after 16th birthday) Dose 1 \_\_\_ \_\_ Dose 2\_\_ \_\_\_\_\_\_

**Students** **19yrs + older** (Resident, 1 Dose after 16th b’day + w/in last 5yrs) Date: \_\_\_\_\_\_\_\_\_\_

**STUDENT NAME** (Last, first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CWID**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**STRONGLY RECOMMENDED (Not required)**

**COVID-19 (Residential students)** Manufacturer name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose 1 \_\_\_\_\_\_\_\_\_\_\_\_\_ Dose 2\_\_\_\_\_\_\_\_\_\_\_\_\_ Add’l doses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Meningococcal B Vaccine**: Serogroup B - Bexsero

Date for dose 1: \_\_\_\_\_\_\_\_\_\_ Date for dose 2: \_\_\_\_\_\_\_\_\_\_

**Meningococcal B Vaccine**: Serogroup B - Trumenba (2 or 3 dose schedule)

Date for dose 1: \_\_\_\_\_\_\_\_\_\_ Date for dose 2: \_\_\_\_\_\_\_\_\_\_ Date for dose 3: \_\_\_\_\_\_\_\_\_\_

**Varicella (Chickenpox) Vaccine**:

Date of dose 1: \_\_\_\_\_\_\_\_\_\_ Date of dose 2: \_\_\_\_\_\_\_\_\_\_

**Tdap** (tetanus, diphtheria and pertussis) Vaccine (this is not the same as DTap):

Date of last Tdap dose: \_\_\_\_\_\_\_\_\_\_

**Td** (tetanus, diphtheria) Vaccine:

Date of last Td dose: \_\_\_\_\_\_\_\_\_\_

**Hepatitis A** (Hep A) Vaccine:

Date of dose 1: \_\_\_\_\_\_\_\_\_\_ Date of dose 2: \_\_\_\_\_\_\_\_\_\_

**Human Papilloma** (HPV) Vaccine: Manufacturer name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of dose 1: \_\_\_\_\_\_\_\_\_\_ Date of dose 2: \_\_\_\_\_\_\_\_\_\_ Date of dose 3: \_\_\_\_\_\_\_\_\_\_

**Pneumococcal** Vaccine 13-Valent: Pneumococcal Vaccine 23-Valent:

Date of dose 1: \_\_\_\_\_\_\_\_\_\_ Date of dose 1: \_\_\_\_\_\_\_\_\_\_

**TST/PPD** (Mantoux): Date: \_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_ Negative \_\_\_\_\_Positive \_\_\_\_\_Induration \_\_\_\_\_mm

**Chest X-ray**: Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INH Therapy** Start Date: \_\_\_\_\_\_\_\_\_\_ Stop Date: \_\_\_\_\_\_\_\_\_\_

**HEALTHCARE PROVIDER**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stamp: