DREW UNIVERSITY HEALTH SERVICE
36 Madison Ave, Madison, NJ 07940   Tel: 973-408-3414

Name: ____Birth date: ______ /______ /______
Last *First* *Middle* *Month* *Day* *Year*

IMMUNIZATION RECORD
To be completed by healthcare provider.
Student: Go to drew.studenthealthportal.com to upload completed form.

REGISTRATION FOR SUBSEQUENT SEMESTERS WILL BE WITHHELD UNTIL THIS INFORMATION IS COMPLETE AND RETURNED TO DREW UNIVERSITY HEALTH SERVICES

REQUIRED Measles, Mumps and Rubella: New Jersey State Law and Drew University requires that all students born after 1956 provide documentation of 2 doses of measles vaccine, 1 dose of mumps and rubella vaccine, or laboratory proof of immunity as a condition of attendance at the institution.

Or ➡ ⬇	FIRST dose given after 1968 and on or after 12 months of age; SECOND dose separated at least 28 days from first dose. MMR #1 ______ / ______ / ______ MMR #2 ______ / ______ / ______ *Month Day Year* *Month Day Year*	OR	Lab Tests (see below) ⬇

Measles (Rubeola), Mumps and RubellaVirus IgG, Antibody test for each demonstrating immunity. Copy of laboratory report including range must be attached.

REQUIRED Hepatitis B: All students enrolled in 12 or more credits per semester are required to have THREE doses of HepB vaccine.

Date dose #1 ______ / ______ / ______ Date dose #2 ______ / ______ / ______ Date dose #3 ______ / ______ / ______
Month Day Year *Month Day Year* *Month Day Year*

REQUIRED Meningococcal Meningitis: New Jersey State Law requires that all new students are vaccinated for meningitis per ACIP guidelines and certain risk factors (see meningococcal vaccine questionnaire). Student will NOT be permitted entry to campus housing unless Health Services has received proof of vaccination. Accepted ONLY if administered on or after 16th birthday and less than 5 years ago.

Meningitis Group A, C, Y, W-135 vaccine **REQUIRED** for all : 18 & younger; 19 & over residing in campus housing; and as indicated on meningitis questionnaire.

Dose #1 Date: _____ / _____ / _____ Dose #2* Date: _____ /____ /____ Circle one: **Menactra** **Menveo** **MenQuadfi**
Month Day Year *Month Day Year*

Meningitis Group B vaccine **REQUIRED** as indicated on meningitis questionnaire; OPTIONAL for others.

Trumemba: Dose#1 Date: ____/____/___ Dose#2 Date: ____/____/____ Dose#3 Date: ____/____/____ **OR**
Month Day Year *Month Day Year* *Month Day Year*

Bexsero: Dose#1 Date: ____/____/____ Dose#2 Date: ____/____/____
Month Day Year *Month Day Year*

RECOMMENDED IMMUNIZATIONS:

Human Papilloma Virus (HPV) 3 injection series

Date dose #1 ______ / ______ / ______ Date dose #2 ______ / ______ / ______ Date dose #3 ______ / ______ / ______
Month Day Year *Month Day Year* *Month Day Year*

Hepatitis A (2 injection series)

Date dose #1 ______ / ______ / ______ Date dose #2 ______ / ______ / ______
Month Day Year *Month Day Year*

Tetanus, Diptheria, Pertussis (most recent injection and please mark vaccine given)

Tdap ______ / ______ / ______ Td ______ / ______ / ______
Month Day Year *Month Day Year*

Varicella (chicken pox): Dose #1 _____/____/____ Dose #2_____/_____/_____
Month Day Year *Month Day Year*

HEALTH CARE PROVIDER NAME, ADDRESS AND SIGNATURE REQUIRED BY NJ STATE LAW				
Name		Telephone		Stamp:
Address		Fax		
Signature		Date		