Revised 01/10/11

MAIL OR FAX TO:

UMDNJ – Student Health Services 90 Bergen Street - DOC Suite 1750

Newark, NJ 07103 Phone: (973) 972-7687 Fax: (973) 972-0018

IMMUNIZATION RECORD

Name	Last		First		
Address	Street	City	State	Zip	
Start Date/_ M Y	Grad. Date/	Date of Birth/_ M _ [Cell #:		
chool Please Check One: NJMSNJDSGSBSSPHSNSHRPVISITING Program Program Rotation					
	-	nust be completed)	Need Ok	
A. ADULT Tdap (TET	ANUS, DIPHTHERIA & ACE	ELLULAR PERTUSSI	S) Adacel TM		
M D Y	umps, Rubella) nonths after birth or later and Dose AS SPECIFIED IN C, D and E:	2 after 1980	#1// M D	#2 Y	
1. Dose 1 of live vaccine a	la) (2 Doses of Live Vaccing at 12 months after birth or later and mmunity (attach lab report	Dose 2 after 1980#1.		М	
// D Y D. RUBELLA (Germa		t & record date of	i iab testj	M	
1. Live vaccine at 12 mon	ths after birth or later		M	_/// // 	
OR	nths after birth or later			M D Y	
	PPD required <u>regardless</u> of pri If Result #1 <u>></u> 10mm, PPD#2		N	D Y	
1. PPD (2 STEP) /	Result #1:	mm induration (horizontal d	diameter). Date read		
M D Y	Result #2:	mm induration (horizontal d	diameter). Date read	<u>Л</u>	
	(induration) : Date read				
	ray required within past 12 mo		**	-	
4. FDA approved blood	l assay for TB(Quantiferon Gold) (a	nttach report)	Date:	/	
3. VARICELLA (Chic				G G	
1. (2 doses required) OR		# 1	//#2// M D Y M E) Y	
2. Serologic immunity	(attach lab results & re	ecord date of lab	<u>test)</u>	/	

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IMMUNIZATION RECORD (CONTINUED)

Name						
Cell #	Last	First	i			
H. Hepatitis At least tv	s B wo of three doses are require	d prior to the start of school:		Health Services Only		
	Dose #1 // M D Y	Dose #2 / / M D Y	Dose #3// M D Y			
I. Hepatitis Required	B Surface Antibody Titer - 1–2 months after dose #3	- Titer must be QUANTITATIVE not (attach lab report)	t qualitative			
	are required, regardless of		M D Y			
J. Hepatitis	B Core antibody must be	lgG or Total (<u>attach lab repo</u>	M D Y	_		
K. Hepatitis	s B Surface antigen <u>(attach</u> ositive, must include L	ı lab report)	M D Y K			
L. Hepatitis	s Be antigen (HBeAg) <u>(atta</u>	ch lab report)				
L required	d only if K is positive		М			
M. Meningococcal vaccine (required for UMDNJ housing application processing) $\frac{1}{M} \frac{1}{D} \frac{1}{Y} = M$						
N. Complete Meningococcal Meningitis Response Form (separate form,-attach) N						
O. Health H	listory & Physical <u>(attach</u>	UMDNJ FORM)				
HEALTH CA	RE PROVIDER (must be comp	pleted):				
Print Name		Address				
Signature				_		
Date		Phone ()		_		
		Fax <u>()</u>				