Raritan Valley COMMUNITY COLLEGE
P. O. Box 3300 ● Somerville, New Jersey 08876-1265
Office of Enrollment Services ● ph: 908-526-1200 ● fax: 908-704-3442

Year: 20_____
Semester: _____ Fall
_____ Spring
_____ Summer

IMMUNIZATION RECORD FORM

Last Name | First Name | Social Security Number | RVCC ID Number | Date of Birth

The State of New Jersey requires all full-time students to be immunized against measles, mumps, rubella (MMR) and Hepatitis B. There are exemptions for the MMR for those who were born before January 1, 1957, for those for whom the administration of an immunizing agent conflicts with religious beliefs, and for those who cannot be immunized for a medical reason. If an outbreak of one of these diseases occurs, any student not having previously submitted proof of the proper immunization (including part-time students and those who are exempt) may be barred from classes until the epidemic is over.

To comply, check one box below, and follow the directions for the option you choose:

☐ Submit proof of immunization (vaccination administered after 1968, on or after first birthday, and second dose administered no less than one month after the first dose). Attach proof of this form and return to the Office of Enrollment Services at the address at the top of this form.

☐ Submit proof of birth before January 1, 1957. Attach a copy of driver's license, passport, or birth certificate to this form and return to the Office of Enrollment Services at the address at the top of this form.

☐ Submit a signed statement, explaining how the administration of an immunizing agent conflicts with your religious beliefs. Attach statement to this form and return to the Office of Enrollment Services at the address at the top of this form.

☐ Submit a signed statement from a physician stating that immunization is medically contraindicated for a specific period of time (the expiration date for the period must be stated and failing to be immunized thereafter will preclude further enrollment), and setting forth the reason(s) for the medical contraindication, based upon valid medical reasons as enumerated by the most recent recommendations of the Advisory Committee On Immunization Practices of the USPHS. Attach that statement to this form and return to the Office of Enrollment Services at the address at the top of this form.

☐ Submit this form, with the information below fully completed and signed by your physician, and return to the Office of Enrollment Services at the address at the top of this form.

1. Hepatitis B (3 doses required) Dose#1__/___/___ Dose#2___/___/___ Dose#3___/___/___ **OR** Titer Date*___/___/___

2. MMR (Measles/Mumps/Rubella Vaccine) – 2 doses required

Dose #1 ___/___/___ (given after one year of age) Dose #2 ___/___/___ (given at least 30 days after Dose #1)

OR:

Measles (2 doses required) Dose#1 ___/___/__ Dose #2 ___/___/___ **OR** Titer Date* ___/___/___

Mumps (1 dose required) Dose#1 ___/___/___ **OR** Titer Date*___/___/___

Rubella (1 dose required) Dose #1 ___/___/___ **OR** Titer Date* ___/___/___

***A copy of laboratory report must be attached to this form if titer results are submitted as documentation.**

Signature of Health Care Provider: _____ Date: ___/___/___ Provider Stamp: _____

For Office Use Only: SAAADMS ____ SOAHOLD ____