DREW UNIVERSITY HEALTH SERVICE

Name: _____Birth date: _____ /_____ /_____
Last First Middle Month Day Year

IMMUNIZATION RECORD
(To Be Completed by Healthcare Provider. Immunization records are NOT confidential as required by law)
Please send all completed, signed documents to:
DREW UNIVERSITY HEALTH SERVICES, 36 Madison Ave, Madison, NJ 07940 Fax: 973-408-3031

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 vaccine or laboratory proof of immunity to Measles, Mumps, and Rubella 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 (Titer). 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 students RESIDING IN HOUSING receive Meningococcal A, C, Y, and W-135 Vaccine. Student will NOT be permitted entry to campus housing unless Health Services has received proof of vaccination. Accepted ONLY if administered less than 5 years ago.

Meningitis Group A, C, Y, W-135 vaccine **(REQUIRED)** : Dose #1 Date: _____ / _____ / _____ Dose #2***** Date: _____ /____ /____
Month Day Year Month Day Year

Meningitis Group B **(OPTIONAL)**: Dose#1 Date: ____/____/___ Dose#2 Date: ____/____/____ Dose#3 Date: ____/____/____
Month Day Year Month Day Year Month Day Year

Circle one: Trumenba Bexsero *****if needed

International Students: Did you receive BCG (Bacille Calmette Guerin) vaccine? Circle one: **Yes** **No**

VOLUNTARY IMMUNIZATION HISTORY
Human Papilloma Virus (HPV) 3 injection series Recommended for all students before age 27
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 correct 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		