



# IMMUNIZATION RECORD

ALL students regardless of birth date must return this completed form to Centenary College Health Services by, July 15th (Fall Semester), January 1<sup>st</sup> (Spring Semester), or May 15th (Summer Semester). Copies of immunization records from High School/College/Public Health Department or Health Care Provider must be attached or your Health Care Provider must complete and sign this form. This information is confidential, except in the case of an emergency, and is **only** used by the Health Services Staff.

Last Name	First	Middle Initial	Social Security Number
Address			Home Phone Number
City	State	Zip	Cell Phone Number
<b>DATE of BIRTH</b>		<b>Date of Entry</b>	Sex M ( ) F ( )
Student Status (circle all that apply) : New Full-Time      Transfer			RESIDENT      COMMUTER
I have previous records at Centenary College			Dates Attended

**\* \* \* \* \* REQUIRED \* \* \* \* \***

New Jersey legislature requires all matriculating students to provide this documentation. Two dates for the live Measles Vaccine, one date for Mumps and Rubella Vaccines or two MMR dates if you were born after 1956. The first dose given after age one and the second after one month, a Mantoux Test (within one year), a Tetanus Booster, DECAVAC or Adacel (within last 10 years), the Meningococcal Vaccine if you are a first time resident, the Hepatitis B Vaccine Series for everyone taking 12 credits (no exemptions).

EXEMPTIONS

Name of Vaccine	Month	Day	Year	Age	Medical	Religious
Measles (Live, 2 doses required)						
Mumps (1 dose required)						
Rubella (1 dose required)						

MMR #	Month	Day	Year	OR	Titer	Date	Copies of Lab results required
MMR # 1					Measles		
MMR # 2					Mumps		
MMR # 3					Rubella		

Mantoux (Tuberculin Skin Test – within one year): \_\_\_\_\_ Read: \_\_\_\_\_ Neg. Pos. Induration \_\_\_\_\_  
 A chest x-ray is required for those with a positive Mantoux. Date: \_\_\_\_\_ Result: \_\_\_\_\_ INH Therapy: Start \_\_\_\_\_ Finish date \_\_\_\_\_  
 Tetanus Booster (within ten years); \_\_\_\_\_, DECAVAC \_\_\_\_\_ or Adacel: \_\_\_\_\_  
 Meningococcal Vaccine (Menactra – preferred) \_\_\_\_\_ or Menomune (accepted alternative) \_\_\_\_\_  
 Hepatitis B Vaccine Series: Dose # 1 \_\_\_\_\_ Dose # 2 \_\_\_\_\_ Dose # 3 \_\_\_\_\_  
 Varicella (Chickenpox) - Disease: (circle) Yes No      Vaccine Series: Dose # 1 \_\_\_\_\_ Dose # 2 \_\_\_\_\_

**\* \* \* \* \* RECOMMENDED BUT NOT REQUIRED \* \* \* \* \***

Flu Vaccine: \_\_\_\_\_ Gardasil Vaccine: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ Polio Booster: \_\_\_\_\_  
 Hepatitis A #1 \_\_\_\_\_ #2 \_\_\_\_\_ Smallpox Vaccine: \_\_\_\_\_ Yellow Fever \_\_\_\_\_ Typhoid \_\_\_\_\_

**SIGNATURE OF HEALTH CARE PROVIDER or SELF:.....** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Or attach copies of immunization record / titer results of immunity

Name of High School: \_\_\_\_\_ State: \_\_\_\_\_ Year Graduated: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_  
 Employer: \_\_\_\_\_

Attach copies of all relevant documents