



IMMUNIZATION RECORD

ALL students regardless of birth date must return this completed form to Centenary College Health Services by, AUGUST 1st (Fall Semester), January 1st (Spring Semester), or June 1st (Summer Semester). Copies of immunization records from High School / College / Public Health Department or Health Care Provider must be attached and 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
Date of Entry		DATE OF BIRTH	
Sex M () F ()			
Status (circle all that apply) : 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 doses for the Measles, Mumps and Rubella Vaccine or MMR if you were born after 1956. The first dose given after age one and the second after age five, the Mantoux (within one year), a Tetanus Diphtheria Booster or Adacel (within last 10 years), the Hepatitis B Vaccine Series and the Meningococcal Vaccine (Menactra preferred or Menomune), if you are a first time resident

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 or those that have had the BCG Vaccine. Date: _____ Result: _____
 Tetanus Diphtheria Booster (within ten years); _____ 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: _____ DATE: _____

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

Attach copies of all relevant documents.