REQUIRED FORM B – COLLEGE OF SAINT ELIZABETH WOMEN'S COLLEGE
START IMMEDIATELY – TIME SENSITIVE REQUIREMENTS!!!

Name_____ Class (year)_____ DOB_____

IMMUNIZATION RECORD

REQUIRED VACCINES – read all instruction documents carefully

Vaccines	Dates Given	College of St. Elizabeth and NJ State Requirements
MMR	#1 ___/ ___/ ___ #2 ___/ ___/ ___ OR Positive Titer Date: ___/ ___/ ___	2 doses or ***positive titers*** (must include copy of lab report within **five years**) Equivocal titles are considered negative Minimum of 4 weeks between doses 1st dose given after 1st birthday Option of combined MMR OR 2 individual vaccine doses of measles, mumps, and rubella vaccines. Single dose vaccines are not manufactured any longer
or Measles	#1 ___ / ___ / ___ #2 ___/ ___ / ___ OR Positive Titer Date: ___/ ___/___	
Mumps	#1 ___ / ___ / ___ #2___ /___ / ___ OR Positive Titer Date ___/___ /___	
Rubella	#1___ /___ / ___ #2___ /___ /___ OR Positive Titer Date: ___ /___ /___	
Meningococcal Vaccine Serogroup ACWY (≥ age 16) Information Sheet	#1 ___ / ___ / ___ #2 ___ / ___ / ___ (≥ age 16) ❑ Menomune ❑ Menactra ❑ Menveo ❑ Meningococcal information sheet sign and submit	**All** students ≤ 21 years. **All** resident students ***Final dose must be at or after the* age of 16 *years old AND within five years of entry*** **All students must read sign and submit meningococcal information sheet**
Hepatitis B	#1 ___/ ___/ ___ #2 ___/ ___/ ___ #3 ___/ ___/___ OR Positive Titer Date: ___/ ___/ ___	3 doses or positive titer (must include copy of lab reports) Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 Minimum of 16 weeks between doses 1 and 3
Interferon-gamma release assay test (IGRA) OR PPD / Mantoux	Interferon-gamma release assay tests (IGRA) ___/___/___ ❑ pos. ❑ neg. copy of report **Or** PPD ___ / ___ / ___ ___/___/___ **result** ___**mm** **Planted** **Read** **Number** Positive PPD in past ___/___/___ BCG history ___/___/___ If PPD or Inteferon-gamma release assay tests (IGRA) is positive, chest x-ray is required: **chest x ray** ___ / ___ / ___ ❑ normal ❑ abnormal INH treatment began ___/___/___ completed ___/___/___	Must send copy of Interferon-gamma release assay tests (IGRA) report **Result must be in:** **mm of induration** **WITHIN ONE YEAR** **must include planted and read dates** Must send copy of Chest X-Ray report
Tdap Td Completed primary series	❑Tdap ___/___/___ ❑Td ___/___/___ ❑DTP ❑DT ___/___/___	**Tdap 1 dose required** Td or Tdap within 10 years
Polio	Primary series: ❑ Oral ❑ Injectable Most recent booster : ___/___/___	Primary series

_____ _____ _____

Signature Health Care Provider Print Name Date

Name: _____ DOB _____

RECOMMENDED VACCINES

Vaccines	Dates Given	Recommendations
Meningitis Serogroup B	#1___/___/___ #2___/___/___ #3___/___/___ ❑ Trumenba ❑ Bexsero	As recommended by the CDC
Varicella (Chicken Pox)	#1 ___/___/___ #2 __ / __ / ___ OR Positive Titer Date: ___ / ___/ ___ History of disease ❑ No ❑Yes Date ____ / ___	2 doses varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses if age 13 or older ***Required by Nutrition and Nursing Departments***
HPV (women)	#1___/___/___ #2___/___/___ #3___/___/___	Preventative health care
Hepatitis A	#1 ___/ ___/ ___ #2 ___/ ___/ ___	Recommended if planning to travel and high risk exposure 6-12 months between doses 1 and 2
Pneumococcal	#1 ___/ ___/ ___ ❑ Polysaccharide (PPV) ❑ Conjugate (PCV)	Chronic health problems
Hib	___ /____/___	Primary series completed

OPTIONAL VACCINES

Vaccines	Dates Given	Recommendations
Typhoid	#1 ____/____/____	Travel
Yellow Fever	#1 ___/____/ ___	Travel

HEALTH CARE PROVIDER

_____ _____ ___/___/___
Signature Print Name Date

_____ _____ _____ _____
Address City State Zip

_____ _____
Telephone Fax

Send Records by mail or fax to:

College of St. Elizabeth Health Services
Founders Hall - 2 Convent Road, Morristown, N.J., 07960
PHONE: 973-290-4175 or 4132 **FAX:** 973-290-4182
Any questions, call Immunization Information Line 973-290-4388