Immunization Record

This form must be signed by a physician or nurse practitioner. Dates must include month/day/year.
Immunization Record must be submitted BEFORE your first semester.

Student Name_____ Rowan ID#_____ Date of Birth _____

Required 2 MMR Vaccinations: All students born AFTER 1956 must have immunization against measles, mumps and rubella (2 MMRs) given after 1968, and ON or AFTER 12 months of age. In lieu of vaccine records, you can submit lab reports showing positive blood titers. [NJ State Law (N.J.A.C. 8:57-6.3)]

MMR (two doses at least 30 days apart)
#1_____
#2_____

OR

Measles #1 _____ #2_____
Mumps #1_____ #2_____
Rubella #1_____ #2_____

Required Hepatitis B Vaccination (series of 3): All students taking 12 or more credits must show proof.

Hepatitis B #1_____ #2_____ #3_____

Required Meningococcal (tetravalent A,C,Y,W-135) Vaccination: All students residing in campus housing and intercollegiate athletes must show proof of meningococcal vaccination. A booster is required if previous dose was 5 or more years before enrollment. A booster is recommended if previous immunization was received before 16 years of age. This vaccine is highly recommended for all students.

Meningococcal vaccine - (Please indicate type given) - Menomune®, Menactra® or Menveo® #1 _____ #2_____

Required for Intercollegiate Athletes (highly recommended for all students):

Tetanus (Td or TT or TdaP) Booster in last 10 years _____

Highly Recommended for All Students:

Varicella #1 _____ #2_____
Hepatitis A #1 _____ #2_____
Inactivated Polio Vaccine (IPV) Booster _____

_____ _____
Signature of Physician/Nurse Practitioner (required to be valid) Date

_____ _____
Address Phone

EXEMPTIONS*

- ❑ **Age** Born in or before 1956 (MMR only). Birth Date _____
- ❑ **Religious** To claim a religious exemption, you must by NJ State Law "submit a written statement explaining how the administration of immunizing agents conflicts with" your religious belief. ***Please use a separate sheet of paper to write your statement. You must sign the statement before mailing it back to the Student Health Center.***
- ❑ Medical (Valid contraindication to vaccination administration, must be for a specific time period, signed by a physician/nurse practitioner and subject to periodic review.)

Physician/Nurse Practitioner statement: _____
_____
Length of Exemption: _____

_____ _____
Signature of Physician/Nurse Practitioner (required to be valid) Date

**In the event of a vaccine preventable disease outbreak the University may exclude students with exemptions from classes or institution-sponsored activities.*