FDU
Student Health Services
Metropolitan Campus

Commuter Student Immunization Record

Rev.10 v4 4.3.2020

NOT CONFIDENTIAL

Immunization records are not confidential as required by law.

Name: _____ Male ☐ Female ☐
Last *First* *Middle*

Student ID: _____ Date of Birth: _____ mm dd yyyy

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR

If convenient, you may attach an official copy of your immunization records, which must include all previous and recent shots

1. REQUIRED IMMUNIZATIONS (Laboratory Report must be submitted for any blood titers)

MMR #1 _____ #2 _____ **OR** **TITERS**

NOTE: MEASLES HAS TO BE LIVE, AFTER 1ST BIRTHDAY

TITER REPORTS MUST BE ATTACHED

Measles #1 _____ #2 _____ Date _____ ☐ Immune Non-immune ☐

Mumps #1 _____ #2 _____ Date _____ ☐ Immune Non-immune ☐

Rubella #1 _____ #2 _____ Date _____ ☐ Immune Non-immune ☐

Hepatitis B #1 _____ #2 _____ #3 _____ **OR** **TITERS** Date _____ ☐ Immune Non-immune ☐

2. MENINGOCOCCAL QUADRIVALENT VACCINE

MENINGOCOCCAL (MENINGITIS) INFORMATION IS AVAILABLE AT:
http://www.cdc.gov/meningitis and
https://www.nj.gov/health/cd/documents/topics/meningo/meningo_requirements_highered.pdf

By signing below I attest to have read and understood the information on the CDC and New Jersey Department of Health website. Any further questions and/or concerns will be clarified by my HealthCare Provider listed below.

☐ I have**received* the meningitis vaccine on: mm-dd-yyyy

*If your initial dose was administered before your 16th birthday, you will be required a booster dose.

STUDENT SIGNATURE: _____ **DATE**: _____

3. TUBERCULOSIS TEST (Must be within one year of starting at FDU, regardless of a BCG vaccine)

Mantoux/PPD Test

Date Given _____ Date Read _____ Result: ☐ Negative *Positive ☐ Size_____mm *(induration)*

OR

QuantiFERON-TB Gold or T-spot Test

Date_____ Result_____ (*LAB REPORT MUST BE ATTACHED)*

***If Mantoux/PPD Test, QuantiFERON Gold or T-Spot Test is Positive, a Chest X-ray (within 5 years) is required.**
Radiologist's report MUST be attached to this form.

Signature of Medical Provider: _____ Date: _____

Medical Provider: _____ Phone:( ) _____

Address: _____

License Number
OR
Official Stamp of Medical Provider

Proof of Immunity is required prior to entrance at the University
You will be placed on medical hold until all the above requirements are met.