Student Health Services
Metropolitan Campus

Off-Site Student Immunization Record

*****FOR STUDENTS TAKING CLASSES ONLY AT A NON-METRO/FLORHAM CAMPUS LOCATION*****

STUDENT HEALTH SERVICES
Metropolitan Campus
1000 River Road, T-SU2-03
Teaneck, New Jersey 07666
Phone: (201) 692-2437
Fax: (201) 692-2642

____ ______________________
Last Name First Name Middle Initial FDU ID#

________________ Male Female (______) - ______________ (______) - ________________
Date of Birth Circle One Cell Phone Home Phone

____ ________________
Street Address City State Zip Code Date Entering FDU

MENINGOCOCCAL MENINGITIS INFORMATIONIS AVAILABLE AT:
http://www.cdc.gov/meningitis and at:
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 NJDH web-site. Further questions and/or concerns have been clarified by my HealthCare Provider listed below.

☐ I received the meningitis vaccine on: MM / DD / YYYY

Please list the location(s) you are attending classes:
1. ______________________
2. ______________________
3. ______________________
4. ______________________

Student Signature: ________________________________ **Date:** MM / DD / YYYY

*** NOTE: ONLINE STUDENTS ARE EXEMPT FROM THE REQUIREMENTS BELOW ***

AS PER NJ ADMINISTRATIVE CODE, TITLE 8, CHAPTER 57, SUBCHAPTER 6, THE FOLLOWING VACCINATIONS ARE REQUIRED OF ALL OFF-SITE FDU STUDENTS ENROLLED IN A PROGRAM LEADING TO A DEGREE

1. **Measles, Mumps, Rubella Vaccination:**
   Required for **ALL graduate and undergraduate students born on or after 01/01/1957**. Students born before 01/01/1957 need to submit proof of birth date.

   FIRST MMR: ______-_____-_________
   MM DD YYYY
   [*On or after one year of age*]

   SECOND MMR: ______-_____-_________
   MM DD YYYY
   [*At least thirty days after first MMR*]

   OPTION: Submit blood titers for Measles, Mumps and Rubella showing immunity. Blood titers must be accompanied by a lab report indicating a numerical value for the titer and a reference range.

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2. **Hepatitis B Vaccination:**
   Required for ALL students taking **12 or more credits in one semester**, regardless of birth date.

   FIRST: _____-_____-_________ MM DD YYYY
   SECOND: _____-_____-_________ MM DD YYYY
   THIRD: _____-_____-_________ MM DD YYYY

   OPTION: Submit HBsAb blood titer showing immunity. Blood titers must be accompanied by a lab report indicating a numerical value for the titer and a reference range.

Medical Provider Signature: ______________________________

Print Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Office Stamp
or
Provider License Number