FAIRLEIGH DICKINSON UNIVERSITY
Florham Campus

Resident Student Immunization Record

v. 4.17.2020

NOT CONFIDENTIAL

Immunization records are not confidential as required by law.

Name: _____ Male ☐ Female ☐
Last First Middle

Student ID#: _____ Date of Birth: _____ m m d d y y y y

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 vaccines to date.

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

MMR #1 _____ #2 _____ **OR** **Titers for MMR**

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

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

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

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

Varicella (Chicken Pox) Disease date _____ **OR** **Titers for Varicella**

OR Vaccine #1 _____ #2 _____ Date _____ Immune ☐ Non-immune ☐

Hepatitis B #1 _____ **OR** **Titers for Hepatitis B**

#2 _____ #3 _____ Date _____ Immune ☐ Non-immune ☐

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. Further questions and/or concerns have been 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**: _____

Tdap (within the last 10 years) Date _____ (TD is not acceptable)

2. TUBERCULOSIS TEST (Must be within 6 months prior to the start date of student's first semester)

Mantoux/PPD Test

Date Given _____ Date Read _____ Result: ☐ Negative *Positive ☐ Size _____ mm *(induration)*
(MUST INDICATE)

QuantiFERON-TB Gold or T-Spot Test **OR**

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.**
Radiologists 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 and residing in the dorm.
You will be placed on a medical hold if the above requirements are not met.