

College of St. Elizabeth Health Service

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 result within one year) Minimum of 4 weeks between doses 1 st dose given after 1 st birthday Option of combined MMR OR individual vaccines
or Measles	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	
Mumps	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date ___/___/___	
Rubella	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	
Meningococcal (resident students)	#1 ___/___/___ <input type="checkbox"/> Menomune <input type="checkbox"/> Menactra	All students must read sign and submit meningococcal information sheet (Menomune within past 5 yrs)
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR Positive Titer Date: ___/___/___	3 doses or positive titer (must include copy of lab results) 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
PPD or Mantoux (within one year)	PPD ___/___/___ ___/___/___ result ___ mm Planted Read Positive PPD in past ___/___/___ INH treatment began ___/___/___ completed ___/___/___ BCG history ___/___/___ If greater than 10 mm or history of +PPD chest x-ray required - copy of report ___/___/___ Chest x ray <input type="checkbox"/> normal <input type="checkbox"/> abnormal	Result must be in mm of induration Must send copy of Chest X-Ray report
Tdap or Td	<input type="checkbox"/> Tdap <input type="checkbox"/> Td #1 ___/___/___	1 Tdap/Td booster within last 10 years
Completed primary series	<input type="checkbox"/> DTP <input type="checkbox"/> DT ___/___/___	
Polio	Primary series: <input type="checkbox"/> Oral <input type="checkbox"/> Injectable Most recent booster : ___/___/___	Primary series

Signature Health Care Provider _____

Print Name _____

Date _____

College of St. Elizabeth Health Service

Name: _____

DOB _____

RECOMMENDED VACCINES

Vaccines	Dates Given	Recommendations
Varicella (Chicken Pox)	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___ History of disease <input type="checkbox"/> No <input type="checkbox"/> Yes Date ___/___	2 doses varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses if age 13 or older
HPV (women)	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	Preventative health care

OPTIONAL VACCINES

Vaccines	Dates Given	Recommendations
Hepatitis A	#1 ___/___/___ #2 ___/___/___	Recommended if planning to travel 6-12 months between doses 1 and 2
Pneumococcal	#1 ___/___/___ <input type="checkbox"/> Polysaccharide (PPV) <input type="checkbox"/> Conjugate (PCV)	Chronic health problems
Typhoid	#1 ___/___/___	Travel
Hib	___/___/___	Primary series completed
Yellow Fever	#1 ___/___/___	Travel

HEALTH CARE PROVIDER

Signature _____ Print Name _____ Date ___/___/___

Address _____

Telephone _____ Fax _____

Send Records by mail or fax to:
College of St. Elizabeth
Health Service - Founders Hall
2 Convent Road, Morristown, N.J., 07960
Tel: 973-290-4175, 4132 Fax: 973-290-4182

If you have any questions please contact us, we will be happy to assist you.