



PISCATAWAY / NEW BRUNSWICK:

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Visiting Student Immunization From

NAME: _____ **SS#** _____ **DOB:** _____

Health Service Use Only (Must Check and Complete ALL. NO LAB REPORTS!)

NEED OK

_____ 1. Complete History and Physical (Within 12 mo.) Date: _____

_____ 2. Tuberculin Testing (Within 12 Months)

PPD Date: _____ Result: _____ mm.

If Positive PPD: Chest X-Ray Yes _____ No _____ Date: _____

Result: Normal _____

Abnormal _____ (Attach Report)

_____ 3. Polio Series (OPV or IPV): _____

_____ 4. Measles, Mumps, Rubella

1. Birthdate Prior to 1957 _____ (Exempt)

Or

2. Two Doses of Vaccine Dates: _____, _____

(After first birthday, no less than one month apart; at least one dose in, or after, 1980)

Or

3. Serologic Immunity Date: _____

_____ 5. Varicella

1. Two Doses of Vaccine Dates: _____

Or

2. Serologic Immunity Date: _____

_____ 6. Hepatitis B

1. Three Doses of Vaccine Dates: _____

Or

2. Serologic Immunity Date: _____

_____ 7. Influenza Date: _____ (Fall / Winter)

_____ 8. Tetanus/Diphtheria (Td) Last Booster - Date: _____

_____ The student **has satisfied** all immunization requirements cited above.

_____ The student **has not satisfied** the _____ Immunization.

Signature (Health Services or Dean)

Print Name

Date

Title