TCNJ THE COLLEGE OF NEW JERSEY

RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY

Must be completed, signed & office stamped by a doctor or nurse; then uploaded by the student into OWL

Student's Name: _____ Birth date: ____/____/____
Last *First* *M D Y*

REQUIRED FOR ALL UNDERGRADUATE STUDENTS:

MEASLES, MUMPS, RUBELLA (MMR) (students born BEFORE 1957 are exempt from the MMR requirement)

OR → ↓	**2 doses of MMR VACCINE** Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE: ____/____/____ (M D Y) Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: ____/____/____ (M D Y)	OR	**LABORATORY PROOF OF IMMUNITY** (see below) ↓
	2 doses of MEASLES VACCINE Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE: ____/____/____ (M D Y) Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: ____/____/____ (M D Y)	OR	MEASLES Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
	2 doses of MUMPS VACCINE Dose 1 RECEIVED ≥ 12 MONTHS OF AGE: ____/____/____ (M D Y) Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: ____/____/____ (M D Y)	OR	MUMPS Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
	1 dose of RUBELLA VACCINE Dose 1 RECEIVED ≥ 12 MONTHS OF AGE: ____/____/____ (M D Y)	OR	RUBELLA Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.

VARICELLA (Chickenpox)

2 doses of VARICELLA VACCINE Dose 1 RECEIVED ≥ 12 MO OF AGE: ____/____/____ (M D Y) Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: ____/____/____ (M D Y)	OR	**LABORATORY PROOF OF IMMUNITY** Varicella Zoster Virus (VZV) IgG Antibody test. Copy of laboratory report must be attached.	OR	**History of Chickenpox Infection** Date: ____/____/____ (M D Y) *History of infection alone is not acceptable for students entering the health care field. Must receive 2 doses of Varicella vaccine or provide proof of immunity to Varicella.*

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)

1 dose of TETANUS, DIPHTHERIA, PERTUSSIS VACCINE RECEIVED ≥ 11 YEARS OF AGE: ____/____/____ (M D Y)

NOTE: Vaccine MUST include Pertussis to be acceptable. If not, revaccinate with Tdap.

Continued on next page

Student's Name: _____ Birth date: ____/____/____
Last First M D Y

REQUIRED FOR STUDENTS TAKING 3 OR MORE COURSE UNITS/SEMESTER (FULL-TIME):

HEPATITIS B (NOTE: If beginning vaccination series, no need to accelerate dosing. Series can be completed at TCNJ)

3 doses of HEPATITIS B VACCINE	OR	3 doses of Combined HEPATITIS A & HEPATITIS B VACCINE	OR	LABORATORY PROOF OF DISEASE OR IMMUNITY TO HEPATITIS B
Dose 1: ____/____/____ M D Y Dose 2: ____/____/____ M D Y Dose 3: ____/____/____ M D Y		Dose 1: ____/____/____ M D Y Dose 2: ____/____/____ M D Y Dose 3: ____/____/____ M D Y		Copy of laboratory report must be attached.

REQUIRED FOR STUDENTS APPLYING FOR TCNJ HOUSING:

MENINGOCOCCAL MENINGITIS A/C/Y/W-135

One dose received within 5 years of arrival on campus: **Most recent dose:** ____/____/____ M D Y

U.S. Brand: ☐ *Menveo (Glaxo)* or *Menactra (Sanofi)* ☐ *Menomune* ☐ *Unknown*

Non-U.S. Brand (specify): _____ NOTE: Trumenba & Bexero are **NOT** ACYW Vaccines

DOCTOR: Give Booster dose if received before age 16 to continue protection during age of highest risk (16-23 years)

Recommended Vaccinations (not required):

HEPATITIS A

Dose 1: ____/____/____ M D Y Dose 2: ____/____/____ M D Y	OR	Combined Hepatitis A & Hepatitis B Vaccine *(Document dates of doses on page in box above)*

HUMAN PAPILLOMAVIRUS (HPV)

Dose 1: ____/____/____ Dose 2: ____/____/____ Dose 3: ____/____/____ **Which one:** _____
M D Y M D Y M D Y

MEN B VACCINE (Meningococcal meningitis B)

Dose 1: ____/____/____ Dose 2: ____/____/____ Dose 3: ____/____/____ **Which one:** ☐ Bexero (Sanofi) ☐ Trumenba (Pfizer)
M D Y M D Y M D Y

Record of Immunization is NOT VALID unless signed & stamped by a PHYSICIAN, PA, APN or RN

Print Name & Title: _____

Signature: _____

Date: _____ Office Telephone: ( ) _____

Office Stamp (REQUIRED)

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

To be completed and signed by the student. Upload into OWL under Physician's Evaluation for Tuberculosis.

Name: _____ **Birth date:** ____/____/____ **PAWS ID:** _____
Last *First* *M D Y*

Please answer the following questions:

1) Have you ever had a **positive** TB test?..... ☐ yes ☐ no

2) Have you ever had **close contact** with persons known or suspected to have active TB disease? ..... ☐ yes ☐ no

3) Were you **born** in one of the countries listed below? If yes, please CIRCLE the country ..... ☐ yes ☐ no

4) Have you had any **frequent** (once per year or more) OR **prolonged visits (30 days or more)** to one or more of the countries listed below? If yes, please CHECK ✔the country/ies below..... ☐ yes ☐ no

5) Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facility, long-term care facility, homeless shelter)?..... ☐ yes ☐ no

6) Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ yes ☐ no

7) Have you ever been a member of any of the following groups that may have an increased incidence of latent TB infection or active TB disease: - medically underserved, low-income, or abusing drugs and/or alcohol?..... ☐ yes ☐ no

I verify that the information provided by me on this form is true. _____ **Date**_____
Student's signature *(or parent/legal guardian if student is a minor)*

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China (including Taiwan)
Colombia
Comoros
Congo (Democratic Republic of)
Côte d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Korea (Republic of)
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
St. Vincent & The Grenadines
Sao Tome & Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Trinidad & Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with TB incidence rates of ≥ 20 cases per 100,000 population.

If you answered YES to one or more of the above questions, schedule an office visit with your doctor to complete the "Physician's Evaluation for Tuberculosis" on the next page (page . TAKE THIS FORM WITH YOU TO YOUR APPOINTMENT.

If you answered NO to all of the above questions, you are NOT required to have the Physician's Evaluation for Tuberculosis form completed or have a TB test.

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Only required if the student has answered YES to one or more questions on PAGE 3, Tuberculosis Screening Questionnaire.
To be completed and signed by a MD/DO, PA, or NP and uploaded into OWL . Requires an office visit to your doctor.

PHYSICIAN'S EVALUATION FOR TUBERCULOSIS

Student's Name: _____ **Birth date:** ____/____/____
Last *First* *M D Y*

1. Has the student had a TB TEST in the past? ☐ Yes ☐ No ☐ Unknown

2. Has the student had a POSITIVE TB test in the past? ☐ Yes ☐ No

   If YES, what test was positive: ☐ Interferon-Gamma Release Assay (IGRA) ☐ TB skin test – Result in mm:_____

   Date of Positive Test: ____/____/____ (M D Y)

   Chest X-Ray Date: ____/____/____ (M D Y) (Copy of Radiologist's report in ENGLISH must be attached) Result: Normal ☐ Abnormal ☐

   Diagnosis: ACTIVE Tuberculosis ☐ Yes ☐ No LATENT Tuberculosis ☐ Yes ☐ No

   Treatment: _____ Completed successfully on ____/____/____ (M D Y)

3. **TB SYMPTOM CHECK**

   Does the student have signs or symptoms of active pulmonary tuberculosis disease?

   No ☐ Proceed to #4

   Yes ☐ Check symptoms present & proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest x-ray, and sputum evaluation as indicated.

   - ☐ Cough (especially if lasting 3 weeks or longer) with or without sputum production
   - ☐ Coughing up blood (hemoptysis)
   - ☐ Chest pain
   - ☐ Loss of appetite
   - ☐ Unexplained weight loss
   - ☐ Night sweats
   - ☐ Fever

4. **TB TEST** - If no history of a Positive TB test, perform one of the following tests within 6 months before start of classes:

   - TB Skin Test: ____/____/____ (M D Y) TB Skin Test read: ____/____/____ (M D Y) Result in mm: _____ Neg ☐ Pos ☐
   - Interferon Gamma Release Assay (IGRA): ____/____/____ (M D Y) Neg ☐ Pos ☐ **Copy of laboratory report must be attached.**

5. **CHEST X-RAY** if TB test noted above is POSITIVE. **Copy of Radiologist's report in ENGLISH must be attached.**

   Date: ____/____/____ (M D Y) Interpretation: Normal ☐ Abnormal ☐

   Diagnosis: ACTIVE Tuberculosis ☐ Yes ☐ No LATENT Tuberculosis ☐ Yes ☐ No Other: _____

NOT VALID unless signed, dated, and stamped by a MD/DO, PA or NP

Print Name & Title: _____

Signature: _____

Date: _____ Office Telephone: ( ) _____

Office Stamp (REQUIRED)

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Student Health Services

AUTHORIZATION TO TREAT A MINOR

Only required for students who will NOT be at least 18 years of age when they arrive on campus.
Page to be completed by the student's parent or court-appointed legal guardian and uploaded into OWL.

I hereby authorize Student Health Services at The College of New Jersey to provide medical and therapeutic care to my minor son/daughter, including but not limited to, diagnostic examinations such as laboratory testing, tuberculosis screening, and the administration of immunizations, or when circumstances require immediate attention, to proceed according to standard medical practice. My child's 18th birthday is _____.

Student's Name: _____ Birth date: ____/____/____ PAWS ID #:_____
Last *First* *M* *D* *Y*

_____ _____ _____ _____
[Print name of parent/legal guardian] [Signature of parent/legal guardian] [Relationship to student] [Date]

Emergency Contact Info:

Cell: ( )_____

Home: ( )_____

Work: ( )_____