RARITAN VALLEY COMMUNITY COLLEGE

Semester: _____ Fall ____Year
_____ Spring ____Year
_____ Summer ___Year
_____ Winter ___Year

IMMUNIZATION RECORD FORM

Last Name **First Name** **RVCC ID Number** **Date of Birth**

The State of New Jersey requires **ALL New** full-time and part-time, degree seeking students age 30 and under to be immunized against **Measles, Mumps, Rubella (MMR) & Hepatitis B Meningococcal Disease MenACWY & MenB (recommended)**. All part-time, non-degree seeking students age 30 and under to be immunized against **Meningococcal Disease MenACWY & MenB (recommended).** Students must provide the following documentation of immunization within your 1st semester at RVCC:

To comply, check one box below, and follow the directions for the option you choose:

☐ **For MMR:** Submit proof of immunization (vaccination administered after 1968, on or after first birthday, and second dose administered no less than one month after the first dose).

☐ **For MMR:** Submit proof of birth if born before January 1, 1957. Attach a copy of driver's license, passport, or birth certificate to this form.

☐ Submit a signed statement, explaining how the administration of an immunizing agent conflicts with your religious beliefs (Religious Exemptions).

☐ Submit a signed statement from a physician stating that immunization is medically contraindicated for a specific period of time (the expiration date for the period must be stated and failing to be immunized thereafter will preclude further enrollment), and setting forth the reason(s) for the medical contraindication, based upon valid medical reasons as enumerated by the most recent recommendations of the Advisory Committee on Immunization Practices of the United States Public Health Service (Medical Exemptions).

☐ Submit this form, with the information below fully completed and signed by your physician

Please attach the proof of vaccination and email to admissions@raritanval.edu

Vaccination Required	Age Requirement	Date (Dose 1) Required	Date (Dose 2) Required	Date (Dose 3) Required	OR *Titer Test Date (A copy of laboratory report must be attached to this form if titer results are submitted as documentation)
MMR Combination (Measles, Mumps & Rubella)	***Age 30 and under***			**Not Applicable**	
Measles	***Age 30 and under***			**Not Applicable**	
Mumps	***Age 30 and under***		**Not Applicable**	**Not Applicable**	
Rubella	***Age 30 and under***		**Not Applicable**	**Not Applicable**	
Hepatitis B	***Age 30 and under***				
MenB (Meningococcal disease) *Recommended Only*	***Age 30 and under***		**Not Applicable**	**Not Applicable**	
MenACWY (Meningococcal disease)	***Age 30 and under***			**Not Applicable**	

Signature of Health Care Provider: _____ Date: ___/___/___ Provider Stamp: _____

For staff use only: ***SAAADMS:*** _____ ***SOAHOLD***_____

NH – 07/06/2023