



Semester: \_\_\_\_\_ Fall \_\_\_\_\_ Year  
 \_\_\_\_\_ Spring \_\_\_\_\_ Year  
 \_\_\_\_\_ Summer \_\_\_\_\_ Year  
 \_\_\_\_\_ Winter \_\_\_\_\_ Year

# IMMUNIZATION RECORD FORM

Last Name	First Name	RVCC ID Number	Date of Birth
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The State of New Jersey requires all full-time and part-time students to be immunized against Measles, Mumps, Rubella (MMR), Hepatitis B, and Meningococcal Disease. All applicants for admission to the College who are seeking a degree or certificate from RVCC and are intending to enroll as full-time (12 credit hours or more per semester) and part-time (11 credits or less) students must provide the following documentation of immunization prior to initial enrollment:

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

- 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).
- Submit proof of birth before January 1, 1957. Attach a copy of driver’s license, passport, or birth certificate to this form and return to the Admissions Office.
- 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 USPHS (Medical Exemptions).
- Submit this form, with the information below fully completed and signed by your physician

Please attach the proof of vaccination to this form and send to RVC Admission Office via Mapping Xpress.

Mapping Xpress : You will need to use your RVCC Student ID# (example: G#) and the Mapping Xpress Password is: RVCC2020# (case sensitive).

Vaccination Required	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)
<b>MMR Combination</b>			<b>Not Applicable</b>	
<b>Measles</b>			<b>Not Applicable</b>	
<b>Mumps</b>		<b>Not Applicable</b>	<b>Not Applicable</b>	
<b>Rubella</b>		<b>Not Applicable</b>	<b>Not Applicable</b>	
<b>Hepatitis B</b>				
<b>Men B (Meningococcal disease)- age 30 and under</b>		<b>Not Applicable</b>	<b>Not Applicable</b>	
<b>MenACWY (Meningococcal disease)- age 30 and under</b>			<b>Not Applicable</b>	

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Provider Stamp: \_\_\_\_\_

For staff use only: SAAADMS: \_\_\_\_\_ SOAHOLD \_\_\_\_\_