RUTGERS
Robert Wood Johnson Medical School
Office of the Registrar
675 Hoes Lane, Room TC-111
Piscataway, NJ 08854-5635
Phone: (732) 235 – 4565 **Fax: (732) 235 - 5078**

Visiting Student Immunization Form

Name:_____ SS#_____ ___ _____DOB_____

Phone:_____ Email:_____

**** DO NOT send Lab reports. ****

Health Service Use Only (Complete all sections)

Need OK

____ _____ 1. Complete History and Physical Date_____
(within 12 months of matriculation into your home school)

____ _____ 2. Tuberculin Testing (within 12 months)
PPD date_____ Result _____mm
If positive PPD: Chest X Ray Normal _____ Abnormal_____ Date_____
(if abnormal, please attach report)

____ _____ 3. Polio immunization (OPV or IPV) _____ _____ _____
Or
serologic immunity Date _____

____ _____ 4. Measles, Mumps, Rubella immunization Dates_____ _____
(After first birthday, no less than one month apart: at least one dose after 1979)
Or
Serologic immunity Dates: Measles _____Mumps _____Rubella _____

____ _____ 5. Varicella
Two doses of vaccine Dates:_____ _____
Or
Serologic immunity Date:_____

____ _____ 6. Hepatitis B
Three doses of vaccine Dates: _____ _____ _____
And
Hepatitis Bs Antibody proving immunity Date: _____

____ _____ 7. Hepatitis B virus testing
Hepatitis B surface Antigen Date:_____ negative _____ positive____
Hepatitis B core Antibody Date: _____ negative _____ positive____

____ _____ 8. Influenza immunization Date:_____ (within one year)

____ _____ 9 DTaP (adacel) immunization (within 10 years) Date: _____

_____ The student **has** satisfied all immunization and immunity requirements cited above.
_____ The student **has not** satisfied the _____immunization/immunity requirement

_____ _____
Physician Signature (Student Health Services) Print Name and Title

_____ _____ _____
address phone number date