Dear Incoming William Paterson University Student,

Congratulations on your recent acceptance to William Paterson University.

All undergraduate and graduate students enrolled in a program of study leading to an academic degree at any four (4) year public or independent institution of higher education in New Jersey are **required** to provide evidence of immunization as a prerequisite to enrollment.

**MMR & Hep B Immunization Requirements apply to students 30 years of age or less**

- **MMR (Measles, Mumps, & Rubella) vaccine** – 2 doses of each required if registered for 1 or more credits. The first dose must be administered on or after your first birthday and the second dose must not be administered any less than one (1) month from the first. *Laboratory blood tests that demonstrate immunity may be submitted in place of vaccination documentation.*
  
  *We must receive a copy of the blood work results in order to verify immunity.*

- **Hepatitis B vaccine** – 3 or 2 dose series - Students who are registered for 12 or more credits only. You must provide proof of a completed Hepatitis B vaccine series. This can either be the three (3) dose pediatric/adult series or two (2) dose adolescent series. *Laboratory blood tests that demonstrate immunity may be submitted in place of vaccination documentation.*
  
  *We must receive a copy of the blood work results in order to verify immunity.*

- **Meningitis ACYW vaccine** – *1 or 2 doses*
  
  *Housing room assignments will not be given until proof of meningitis immunization is provided.*

  NJ State law requires ALL students who intend to live in the residence life halls on campus must provide documented proof of the meningococcal conjugate vaccine(s).

  *Recommendations are two doses of meningitis (ACYW) for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16. If the first dose (or series) is given between 13 and 15 years of age, the booster must be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.*

- **Meningitis Survey** – ALL incoming students must complete the survey via the Student Health Portal

  **Students are required to enter required immunization dates into the Student Health Portal and then submit immunization documents as directed on the Portal. Access to the portal is available starting January 5th (Spring Semester) and May 20th (Summer & Fall Semesters) for incoming students**

**Instructions on how to submit immunization records**

1. Log into: WPConnect > Student > General Services > Student Health Portal
2. Go to FORMS tab in Student Health Portal to enter vaccine dates & upload this completed form -or- a copy of your official immunization records.

For any difficulty with the Student Health Portal, please email: WPUimmunization@wpunj.edu

Students who do not comply will have a registration hold placed on their account until the immunization records are received.
Deadlines: All documentation must be received by **July 1st** for the fall semester & **December 15th** for the spring semester

Student Name: ___________________________    __________________________   Student ID# 855__________

DOB: _____ / _______ / _________                  Check all that apply:            

- Resident (living on campus)                     Readmit
- Commuter                                           EOF

If you do not have a copy of your **official immunization records** to submit, then the form below must be completed by a healthcare provider, high school, college/university or any authorized agency.

**MMR & Hepatitis B vaccine records are only required for undergraduate and graduate students who are 30 years of age or less**

1. **MMR (Measles, Mumps, & Rubella) vaccine** – **2 doses of each required if registered for 1 or more credits**

   - Dose #1 _____ / ______ / _____ (Given on or after 1 year of age)
   - Dose #2 _____ / ______ / _____ (Given at least 30 days after Dose #1)
   
   *OR: Titer date: _____ / _____ / _____  *Copy of laboratory report must be attached

2. **Hepatitis B vaccine** – **Required if registered for 12 or more credits per semester**

   Proof of a 3-dose series or a valid adolescent 2-dose series is required

   - Dose #1 _____ / _____ / _____
   - Dose #2 _____ / _____ / _____
   - Dose #3 _____ / _____ / _____

   Check box if 2-dose series (valid between age 11-15 only)

   *OR: Titer date: _____ / _____ / _____  *Copy of laboratory report must be attached

3. **Meningococcal conjugate (ACYW) vaccine** - for ALL undergraduate and graduate students **(who intend to reside on campus)**:

   - Housing assignments will not be provided to the student until proof of meningitis immunization is provided

   - Dose #1 _____ / _____ / _____ Menactra® or Menveo®
   - Dose #2 (*if needed) _____ / _____ / _____ Menactra® or Menveo®

   *Two doses of meningitis are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16. If the first dose (or series) is given between 13 and 15 years of age, the booster must be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed

4. **Immunizations recommended** by WPU and American College Health Association:

   1. **Meningococcal Group B (Men B)**: Dose #1 _____ / _____ / _____ Dose #2 _____ / _____ / _____ *Trumenba® or Bexsero®

      *All doses of Men B must be of the same brand name

   2. **Tetanus**: _____ / _____ / _____ (within the last 10 years)  **Circle Type**: Td  Tdap

   3. **Varicella** (Chicken Pox): Dose #1 _____ / _____ / _____ Dose #2 _____ / _____ / _____  □ Hx of Disease? Year ______

   4. **HPV**: Dose #1 _____ / _____ / _____ Dose #2 _____ / _____ / _____ Dose #3 _____ / _____ / _____

   5. **Mantoux/PPD**: Date Placed: _____ / _____ / _____ Date Read: _____ / _____ / _____ Reaction: ___ mm Result: Pos  Neg

      - CXR Date if PPD is positive: _____ / _____ / _____  **Result**: Positive  Negative

      - **INH Therapy**: Start date: _____ / _____ / _____ End date: _____ / _____ / _____

      - **Specify Reason If No Further Treatment Indicated**: __________________________________________________________

Provider’s Printed Name: ____________________________________________

Provider’s Signature: ______________________________________________

Date: ____________________________

**Provider Stamp is Required**