Immunization Reporting Form

Office of Student Services 475 Route 57 West
Washington, NJ 07882 (908) 835-2300

PART 1: To be completed by the student.

Last Name:	First Name:	MI:	Maiden/Former Name:

Street Address:	City:	State:	Zip Code:

Warren Student ID:	Date of Birth:	Phone #:	Email:

PART 2: To be completed and signed by a licensed health care provider.

Vaccine	Date Dose #1	Date Dose #2	Date Dose #3	OR	Date of Immune Titer Test
MMR (Measles, Mumps, Rubella) 2 Doses Required or Immune Titer (All doses of MMR, given singly or in combination, must be given after 1 year of age and at least one month apart. MMR requirement is only for those born in 1957 or later.)			N/A		
OR					
Measles (2 Doses Required or Immune Titer)			N/A		
Mumps (1 Dose Required or Immune Titer)		N/A	N/A		
Rubella (1 Dose Required or Immune Titer)		N/A	N/A		
AND					
Hepatitis B (3 Doses Required or Immune Titer)					
Meningococcal ACWY (2 Doses Required or at least one (1) dose since age 16)			N/A		N/A
Meningococcal B (not required but some students may have received and should be noted)			N/A		N/A

Health Care Provider Information:

Name (please print):			
Street Address:			
City:	State:	Zip Code:	Phone:
Signature:			Date:

Office Use Only

Missing Immunizations (Check One)	None:	MMR:	Hep B:	Men:

Date Entered:		Staff Initial:		Date Student Notified of Missing Immunizations:	

Updated: June 2021