



Immunization Record

Registrar's Office

1 College Hill Rd, Newton, NJ 07860 | registrar@sussex.edu

PART 1: To be completed by the student.

Last Name:		First Name:		MI:	Maiden/Former Name:	
Street Address:			City:		State:	Zip Code:
SCCC ID:	DOB:	Phone #:	Student Email:			
						@student.sussex.edu

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

Vaccine	Date Dose #1	Date Dose #2	Date Dose #3	O R	Date of Immune Titer Test
MMR (Measles, Mumps, Rubella) 2 Doses Required or Immune Titer <small>(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.)</small>			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
OPTIONAL					
Meningococcal B (not required but some students may have received and should be noted)			N/A		N/A
COVID (not required but some students may have received and should be noted)					

Health Care Provider Information:

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