



**OFFICE OF REGISTRATION & RECORDS**

College Drive • P.O. Box 2001  
Toms River, NJ 08754-2001  
PHONE 732-255-0304  
FAX 732-864-3849  
TTY & VOICE RELAY 711

**IMMUNIZATION RECORD FORM**

Student ID \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI

In accordance with New Jersey law, all new on-campus students **30 years of age or younger** carrying 12 or more credits are required to submit a record of immunization against Meningococcal disease, Measles, Mumps, Rubella, and Hepatitis B or indicate exemption due to medical or religious beliefs.

<b>This section to be filled out by a certified Health Care Provider (MD, DO, or APN)</b>			
<b>Vaccine</b>	<b>Date of 1st Dose</b>	<b>Date of 2nd Dose</b>	<b>Date of 3rd Dose</b>
MenB (Meningococcal disease)		N/A	N/A
MenACWY (Meningococcal disease)			N/A
Measles			N/A
Mumps			N/A
Rubella			N/A
MMR			N/A
Hepatitis B			

OR please provide a documented laboratory proof of a MMR Titer or a Hepatitis B Titer if no date is recorded for immunizations.

MMR(Measles, Mumps, Rubella) Titer	Date
Hepatitis B Titer	Date

OR check and complete fully the below medical exemption

Immunization of this patient is medically contraindicated for a specific period of time from \_\_\_\_\_ to \_\_\_\_\_ (the expiration date for the period must be stated).

Indicate the reason(s) for the medical contraindication, based upon valid medical practices as enumerated by the most recent recommendations of the Advisory Committee on Immunization Practices of the United States Public Health Service (USPHS):

\_\_\_\_\_  
I certify the above information.

\_\_\_\_\_  
Health Care Provider Name

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

**Religious Exemption**

Indicate how the administration of an immunizing agent conflicts with your religious beliefs:

\_\_\_\_\_

\_\_\_\_\_  
Student or Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

**Please email the completed form to regforms@ocean.edu**