



## Immunization Form

Complete the form attached. Missing or unclear information will delay processing of these requirements. The section for healthcare providers **MUST** be completed by a healthcare provider. Forms signed by students or parent/guardian cannot be accepted. All forms mailed must be sent to the address listed below. Do not submit documentation to any other department. Forms may be faxed to Enrollment Services at 973-877-3446. **Your student ID or social security number MUST be on the form/s.**

New student enrolling in a program leading to an academic degree, who registers for 12 or more credits per semester, shall be vaccinated and records submitted to the office. Immunization documentation from a high school or other college/university will be accepted in place of the form attached. Copies of original immunization records from health departments or other countries will also be accepted. Please do not send originals. **Originals will not be returned!**

**Exemptions:** To request a religious exemption, a letter must be submitted from the enrolled student if over age eighteen stating specific religious doctrine that prohibits immunization. Letters from parents or religious leaders will not be accepted. To request a medical exemption, a written statement from your healthcare provider must be submitted stating the specific vaccine contraindicated for a specific period of time and the medical condition. Students born prior to 1957 are exempt from the immunization requirement. Non degree seeking (non-matriculated) and part-time students are exempt from the immunization requirement.

Specific detail of New Jersey immunization regulations may be found at [www.cdc.gov](http://www.cdc.gov). Questions should be sent to Enrollment Services at (973) 877-3100.

Completed forms should be mailed or faxed to:

**Essex County College  
Enrollment Services  
303 University Avenue  
Newark, New Jersey 07102  
Attn: Student Health and Immunizations**

# Essex County College Immunization Form

**Part 1: To be completed by student**

Name _____				
Last (Please Print)	First	MI		
Address _____				
Street	Apt	City	State	Zip Code
Phone number (____) ____ - ____    DOB ____/____/____    ECC ID # _____ - _____ - _____				

**Part 2: Immunization History**- To be complete by a Health Care Provider. Mandatory, two vaccinations for Measles, One vaccination for mumps and rubella or two doses of MMR AND three doses of Hepatitis B.

Vaccine	Date of Dose 1	Date of Dose 2	Date of Dose 3
Measles			N/A
Mumps			N/A
Rubella			N/A
MMR			N/A
Hepatitis B			

OR

MMR Titer	Date:
Hepatitis B Titer	Date:

**Part 3: Healthcare Provider Signature**- Must be signed and stamp.

I certify that the above named student has received measles, mumps, rubella and Hepatitis B vaccines as described. The dates indicate when immunizations were given.

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

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

Office Number (\_\_\_\_) \_\_\_\_\_

Office Address \_\_\_\_\_

Include Official Stamp