



Student Health Center
2083 Lawrenceville Road
Lawrenceville, NJ 08648
T 609-896-5060 F 609-895-5682
www.rider.edu

Student Health Requirement Form
Graduate Students
(Return prior to registration)

Student ID: _____ F/T P/T Email: _____

Name: _____

Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Allergies: _____

Date of Birth: _____ Sex: Male Female Gender: _____

In Case of Emergency:

Name: _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____

I hereby grant permission to the Health Services personnel to contact the person named above in the event of a medical emergency.

**Students age 31 or older do not have to show proof of immunizations. I am over age 31. Yes

Complete top portion only, sign and return to Rider University Student Health Center**

STUDENT'S SIGNATURE: _____ Date: _____

Please provide proof of mandatory vaccinations.

If immunization records are attached, the bottom portion of this form does not need to be completed.

MMR Vaccine (Measles, Mumps, Rubella) **ALL STUDENTS**

Two Vaccines are required

1st Date: ____/____/____

2nd Date: ____/____/____

(Must be on or after 1st birthday)

OR

Antibody Titers (Attach lab slip if titer is being used to complete this requirement – IgG Antibody)

Hepatitis B Vaccine **REQUIRED IF FULL TIME STUDENT – 9 or more credits**

Three Vaccines are required

1st Date: ____/____/____ 2nd Date: ____/____/____ 3rd Date: ____/____/____

OR

Antibody Titers (Attach lab slip if titer is being used to complete this requirement – IgG Antibody)

Meningitis Vaccine **REQUIRED IF LIVING ON CAMPUS**

Date: ____/____/____

Provider's Name: _____ Title: _____

Signature of: _____ Date: _____

Address: _____ City: _____ State _____ Zip _____

Telephone: () _____

Provider's Stamp Required

Empty box for Provider's Stamp