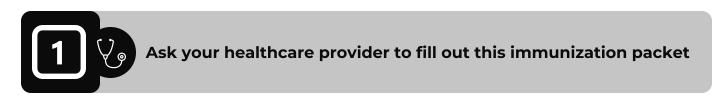


Immunization Packet Instructions

This form is for the following Nursing Continuing Education programs ONLY:

- RN Skill Refresher (RNF)
- Operating Room Nurse (OR)

All forms and uploads must be completed at: https://redcap.link/2y54qcyh





Upload your signed, completed packet and any supporting documentation, if applicable (ex: labs, blood work, x-ray report)

Clinical students (category 1) immunization requirements apply to students who will see patients or clients during the course of their program and may be exposed to blood or body fluids. Not sure of your category? Reach out to your program.

Required: Measles Mumps Rubella Hepatitis B, including labs for immunity Adult Tdap **Tuberculosis screening** Varicella Annual flu

May be required (see immunization form for details): Meningitis ACYW Meningitis B





Student to complete

Last name	 First name	 DOB (mm/dd/yyyy)	
RUID or A number	 Email	 Cell phone	
School/Program	 	 Grad year	

Healthcare provider to complete

Healthcare provider name (print):	Date	Practice stamp
Healthcare provider name (sign):		
NPI:		

Measles, Mumps, Rubella (MMR) – Complete option A, B, or C to fulfill this requirement						
Option A: MMR vaccine doses	Vaccine/Titer	Date (mm/dd/yyyy)	Result			
First dose on or after first birthday and a	MMR dose 1	//				
second dose at least 28 days after.	MMR dose 2	//				
Option B: MMR serological immunity	Measles (Rubeola)					
To satisfy this option, blood tests must	titer	//	🗆 Immune	Non-Immune		
demonstrate immunity to measles, mumps, and rubella. LAB REPORTS ARE REQUIRED AND MUST BE	Mumps titer	//	🗆 Immune	Non-Immune		
UPLOADED AS AN ATTACHMENT	Rubella titer	//	🗆 Immune	Non-Immune		
Option C: Measles, Mumps and Rubella	Measles dose 1	//				
immunizations if given separately. Doses may be entered individually in this	Measles dose 2	//				
section.	Mumps dose 1	//				
	Mumps dose 2	//				
DO NOT RE-ENTER DOSES IF LISTED ABOVE	Rubella dose 1	//				

Hepatitis B – Complete Section A and B						
Section A: Hep B antibody test	Test	Date (mm/dd/yyyy)	Lab Results			
To satisfy the requirement, you must supply a	<u>Quantitative</u>		□ Immune (≥10 mIU/mL)			
QUANTITATIVE Hep B Surface Antibody test	Hep B surface	//	Non-immune (If you are non-			
showing immunity to Hepatitis B.	antibody		immune you must complete the			
LAB REPORTS ARE REQUIRED AND MUST BE			Hepatitis B surface antigen test**)			
UPLOADED AS AN ATTACHMENT			Lab Report Attached			
**Hep B surface antigen test						
We recommend submitting a Hep B Surface	Hep B surface		Negative Positive			
Antigen in case the quantitative Hep B	antigen	//				
Surface Antibody does not demonstrate			Lab Report Attached			
immunity.						



varicella.

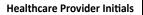
ATTACHMENT

LAB REPORTS ARE REQUIRED AND

MUST BE UPLOADED AS AN

Last name First	name	ne DOB (mm/dd/yyyy) RUID or A number						
Section B: Hep B vaccine doses		Vaccine		Date (mm/dd/yy	/vv)	Manufactu	rer	
If starting the series, at least one dos	e is	Hep B dose	e 1	/ /		Engerix	□ Twinrix	Heplisav
required prior to enrollment.		Hep B dose				🗆 Engerix	Twinrix	□ Heplisav
		Hep B dose				Engerix		
Adult Tdap (Tetanus, Diphtheria & A	cellular Pert	•				□ Adacel		,
				//				<u> </u>
Annual Influenza – List vaccination	for the curre	ent flu seaso	n	//				
Tuberculosis (TB) Screening – Com	olete option	A or B to fu	lfill th	is requirement				
Option A: PPD (Mantoux) skin tests				PPD placed		PPD read		Induration
Required regardless of prior BCG vac	cination.		000	-			,	
To complete this option: 2 step PPD (consisting of 2 PPDs plac	od 1_3 wook	rs anart	PPD	//		/	/	mm
and read 48-72 hours after placemer		-	PPD	2//		/	/	mm
months of your enrollment date.			Both tests must be < 10mm.					
 If yes, list date of the positive PPD and induration. Was the student treated? □Yes □No If yes, for how long was the student treated and wing <u>If PPD is positive</u>: option B or a chest x-ray** must Option B: FDA approved blood test To complete this option, you must supply an FDA approved blood test showing absence of TB infection within the past 6 months of your enrollment date. <u>Lab report must be attached.</u> <u>If your TB Blood test result is positive</u>, a chest x-ray** 			h whi e com Bloo Date Type	ch medication?	Gold		egative 🗆	Positive
**Chest x-ray result			Ches	t x-ray				
If you did NOT have a positive PPD or positive blood test, do NOT complete this option. To complete this option a chest x-ray within the past 6 months must be <u>normal</u> , and <u>report must be attached.</u>		ne past 6	Date:/ Normal Debugger Deb					
Varicella (Chicken Pox) – Complete	option A or	B to fulfill th	nis req	uirement				
Option A: Varicella vaccine doses	Vacci	ne	D	ate (mm/dd/yyyy))	Result		
First dose on or after your first birtho		ella dose 1		//	_			
and a second dose at least 28 days a	part Varic	ella dose 2		//				
Option B: Varicella serologic immun	ity							

To satisfy this option, you must submit a blood test demonstrating immunity to □ Immune □ Non-Immune Varicella titer Lab Report attached



R	RUTGERS
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Last name		First name	<u> </u>		DOB (mm/dd/yyyy)		RUID or A number	
Meningitis ACYW and Meningitis B – Meningitis vaccines are required for students who meet the criteria listed below. Please complete the assessment to determine your requirement.								
•		-	-					
Meningitis ACYW r	equiremen	t assessm	ient					
Check all that apply	below.							
You will be under 1								
	This will be your first year in any college and you will be living in campus housing, regardless of your age							
	 (A transfer or graduate student would NOT be considered a first-year college student, even though they may be new to Rutgers) You have one or more of the following conditions: asplenia, sickle cell, N. meningitidis lab work, complement deficiency or complement 							
	ore of the fo	llowing con	ditions: aspler	nia, sickle ce	ell, N. meningitid	is lab work, comp	plement deficiency	or complement
inhibitor use, HIV								
	 You are a traveler to/resident of areas with endemic meningitis If you checked any of the boxes above, you must receive at least one dose of an approved Meningitis ACYW. 							
		s above, y					eningitis ACYW.	
Meningitis ACYW	Vaccine		Date (mm/d	ld/yyyy)	Manufacturer	•		
The most recent			,	,				
dose must be on	Men ACYV	V dose 1	/]	Menveo	Menactra	Menomune	MenQuadfi
or after your 16th								
birthday.	Men ACYV	V dose 2	/]	Menveo	Menactra	Menomune	MenQuadfi
Meningitis B requi	irement as	sessmen	t					
Check all that apply								
□ You have one or m		llowing con	ditions: aspler	nia. sickle ce	ell. N. meningitid	is lab work. com	plement deficiency	or complement
inhibitor use, HIV				,			,	
 You are a traveler t 	o/resident o	f areas with	n endemic mei	ningitis				
If you checked any o					ingitis vaccinat	ion B series.		
Meningitis B	Vaccine		Date (mm/		Manufacturer			
0.11	Men B dose 1/		_/	🗆 Trumenba		🗆 Bexsero		
	Men B dos	se 2	//		🗆 Trumenba		🗆 Bexsero	
	Men B dos	se 3	//					
Please tell us if you've received the following vaccine. It is highly recommended but not required.								
Vaccine		Date (mn	n/dd/yyyy)	Manufac	turer			
Human Papilloma V	irus	/		🗆 Gardas		sil 9 🗆 Cerva	rix 🗆 Unknow	n
	/ / / Gardasil 4 Gardasil 9 Cervarix Unknown					n		

Please tell us about additional vaccinations you may have received.

□ Gardasil 9

Cervarix

🗆 Unknown

Gardasil 4

/

/

Vaccine	Date (mm/dd/yyyy)	
COVID-19 (most recent dose)	//	🗆 Pfizer 🗆 Moderna 🗆 Novavax 🗆 Other
Hepatitis A	//	/
Japanese Encephalitis	//	//
Pneumococcal	//	□ PCV13 □ PPSV23
	//	□ PCV13 □ PPSV23
	//	□ PCV13 □ PPSV23
	//	□ PCV13 □ PPSV23
Polio Booster	//	



Last name	First name	DOB (mm/dd/yyyy)	RUID or A number
Rabies	//		
	//		
	//		
Typhoid (most recent dose)	//	TyphIM Vivotif	
Yellow Fever	//		



Physical Form

Your healthcare provider may supply their own physical form/document, which you may upload as documentation of your physical exam in lieu of using this form.

Student to complete

Last name	First name	DOB (mm/dd/yyyy)	
RUID or A number	Email	Cell phone	
School/Program		Grad year	

Healthcare provider to complete

PHYSICAL EXAM (Must be completed by a non-relative physician, nurse practitioner, or physician's assistant)

Exam Date:				
Height (inches):			Weight (pounds)):
BMI:		BP:		Pulse:
	Normal	Abnormal	If abnormal, please explai	n:
General appearance				
Skin				
Head				
Eyes				
Neurological Exam				
Respiratory				
Psychiatric Exam				

Healthcare provider name (print):	Date	Practice stamp
Healthcare provider name (sign):		
NPI:		