RUTGERS

This form is for visiting and continuing education students in clinical programs

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

1. **Ask your healthcare provider to fill out this immunization packet**

2. **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

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

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

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Healthcare Provider Initials	

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Section B: Hep B vaccine doses If starting the series, at least one dose is required prior to enrollment.	**Vaccine**	**Date** (mm/dd/yyyy)	**Manufacturer**
	Hep B dose 1	_____/_____/_____	□ Engerix □ Twinrix □ Heplisav
	Hep B dose 2	_____/_____/_____	□ Engerix □ Twinrix □ Heplisav
	Hep B dose 3	_____/_____/_____	□ Engerix □ Twinrix
Adult Tdap *(Tetanus, Diphtheria & Acellular Pertussis)*		_____/_____/_____	□ Adacel □ Boostrix

Annual Influenza – *List vaccination for the current flu season*	_____/_____/_____

Tuberculosis (TB) Screening – *Complete option A or B to fulfill this requirement*

Option A: PPD (Mantoux) skin tests
Required regardless of prior BCG vaccination.
To complete this option:
2 step PPD (consisting of 2 PPDs placed 1-3 weeks apart and read 48-72 hours after placement) within the past 6 months of your enrollment date.

	PPD placed	**PPD read**	**Induration**
PPD 1	_____/_____/_____	_____/_____/_____	_____ mm
PPD 2	_____/_____/_____	_____/_____/_____	_____ mm

Both tests must be < 10mm.

If PPD is positive (≥ 10mm), is the student free of TB symptoms? □Yes □No
If yes, list date of the positive PPD and induration. _____/_____/_____, _____ mm
Was the student treated? □Yes □No
If yes, for how long was the student treated and with which medication? _____
If PPD is positive: option B or a chest x-ray** must be completed.

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.
Lab report must be attached.
If your TB Blood test result is positive, a chest x-ray** must be completed.

Blood test
Date: _____/_____/_____ Result: □ Negative □ Positive
Type: □ QuantiFERON Gold □ T-Spot

□ Lab Report attached

****Chest x-ray result**
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 **normal**, and **report must be attached.***

Chest x-ray
Date: _____/_____/_____
□ Normal □ Abnormal _____
□ Report attached

Varicella (Chicken Pox) – *Complete option A or B to fulfill this requirement*

Option A: Varicella vaccine doses First dose on or after your first birthday and a second dose at least 28 days apart	**Vaccine**	**Date** (mm/dd/yyyy)	**Result**
	Varicella dose 1	_____/_____/_____	
	Varicella dose 2	_____/_____/_____	
Option B: Varicella serologic immunity To satisfy this option, you must submit a blood test demonstrating immunity to varicella. **LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT**	**Varicella titer**	_____/_____/_____	□ Immune □ Non-Immune □ Lab Report attached

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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 requirement assessment

Check all that apply below.

- □ You will be under 19 years old at the start of your first semester
- □ 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 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.

Meningitis ACYW	**Vaccine**	**Date** *(mm/dd/yyyy)*	**Manufacturer**			
The most recent dose must be on or after your 16th birthday.	Men ACYW dose 1	_____/_____/_____	□ Menveo	□ Menactra	□ Menomune	□ MenQuadfi
	Men ACYW dose 2	_____/_____/_____	□ Menveo	□ Menactra	□ Menomune	□ MenQuadfi

Meningitis B requirement assessment

Check all that apply below.

- □ You have one or more of the following conditions: asplenia, sickle cell, N. meningitidis lab work, complement 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 a Meningitis vaccination B series.

Meningitis B	**Vaccine**	**Date** *(mm/dd/yyyy)*	**Manufacturer**	
	Men B dose 1	_____/_____/_____	□ Trumenba	□ Bexsero
	Men B dose 2	_____/_____/_____	□ Trumenba	□ Bexsero
	Men B dose 3	_____/_____/_____	□ Trumenba	

Please tell us if you've received the following vaccine. It is highly recommended but not required.

Vaccine	**Date** *(mm/dd/yyyy)*	**Manufacturer**			
Human Papilloma Virus	_____/_____/_____	□ Gardasil 4	□ Gardasil 9	□ Cervarix	□ Unknown
	_____/_____/_____	□ Gardasil 4	□ Gardasil 9	□ Cervarix	□ Unknown
	_____/_____/_____	□ Gardasil 4	□ Gardasil 9	□ Cervarix	□ Unknown

Please tell us about additional vaccinations you may have received.

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	_____/_____/_____	

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Rabies	_____/_____/_____ _____/_____/_____ _____/_____/_____	
Typhoid *(most recent dose)*	_____/_____/_____	□ TyphIM □ Vivotif
Yellow Fever	_____/_____/_____	

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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 explain:
General appearance	☐	☐	_____
Skin	☐	☐	_____
Head	☐	☐	_____
Eyes	☐	☐	_____
Neurological Exam	☐	☐	_____
Respiratory	☐	☐	_____
Psychiatric Exam	☐	☐	_____

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