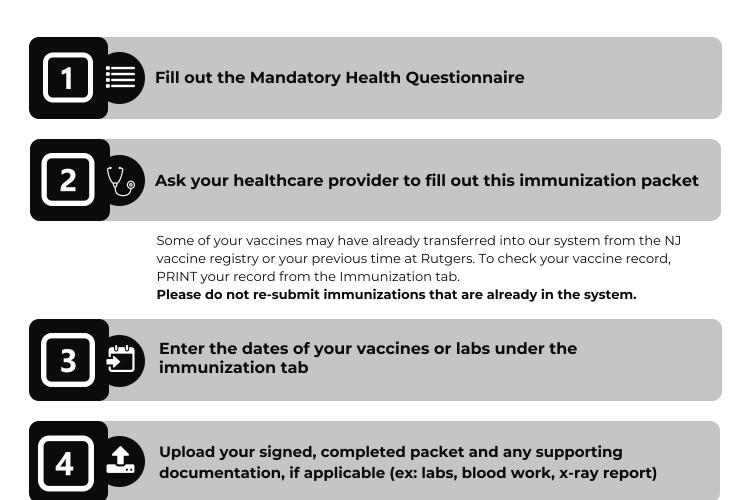


# **Immunization Packet - 4 steps**

All forms and uploads must be completed at https://rutgers.medicatconnect.com



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 Physical Exam <u>May be required (see immunization form for details):</u> Meningitis ACYW Meningitis B



## Student to complete

Last name	First name	 DOB ( <i>mm/dd/yyyy</i> )	
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			
<b>Option C: Measles, Mumps and Rubella</b>	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.			



blood test demonstrating immunity to

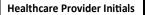
LAB REPORTS ARE REQUIRED AND

MUST BE UPLOADED AS AN

varicella.

ATTACHMENT

Last name First name		_ D	OB (mm/dd/yyyy)	RUID	or A number	
Section B: Hep B vaccine doses	Vaccine		Date (mm/dd/yyyy)	Manufactu	ror	
If starting the series, at least one dose is	Hep B dos	e 1		□ Engerix		Heplisav
required prior to enrollment.				-		-
	Hep B dos		//	Engerix		Heplisav
	Hep B dos	ie 3	/	Engerix	Twinrix	
Adult Tdap (Tetanus, Diphtheria & Acellul	ar Pertussis)		//	Adacel	🗆 Boostrix	(
Annual Influenza – List vaccination for th	e current flu seas	on	//			
Tuberculosis (TB) Screening – Complete	option A or B to fu	ılfill th	nis requirement			
Option A: PPD (Mantoux) skin tests			· · · ·			
Required regardless of prior BCG vaccinati	ion.		PPD placed	PPD read		Induration
To complete this option:	-	PPD	1 / /	/	/	mm
2 step PPD (consisting of 2 PPDs placed 1-	3 weeks apart	000	· · · · · ·	,		
and read 48-72 hours after placement) wi	thin the past 6	PPD	<b>Z</b> //	/	/	mm
months of your enrollment date.	· · · · ·	Both	h tests must be < 10mm			
If PPD is positive (≥ 10mm), is the stude If yes, list date of the positive PPD Was the student treated? □Yes If yes, for how long was the stude <u>If PPD is positive</u> : option B or a che <b>Option B: FDA approved blood test</b> To complete this option, you must supply approved blood test showing absence of T within the past 6 months of your enrollment <u>Lab report must be attached.</u> <u>If your TB Blood test result is positive</u> , a che must be completed.	and induration No nt treated and wit est x-ray** must b an FDA B infection ent date.	th whi be con Date Type Date	//, r ich medication? npleted. od test e:// e:		legative □	Positive
**Chest x-ray result			st x-ray			
If you did NOT have a positive PPD or	•	Date://				
test, do NOT complete this option.		Normal     Abnormal				
To complete this option a chest x-ray w	•	□ Re	eport attached			
months must be <b>normal</b> , and <b>report m</b>	<u>ust be attachea.</u>					
Varicella (Chicken Pox) – Complete optio	n A or B to fulfill t	his red	quirement			
Option A: Varicella vaccine doses	Vaccine		Date (mm/dd/yyyy)	Result		
First dose on or after your first birthday	Varicella dose 1		//			
and a second dose at least 28 days apart	Varicella dose 2		//			
<b>Option B: Varicella serologic immunity</b> To satisfy this option, you must submit a						



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Last name		First name	ne		DOB (mm/dd/yyyy)		RUID or A number	
Meningitis ACYW a complete the assessme	-		-	ines are req	uired for student	s who meet the c	riteria listed below.	. Please
Meningitis ACYW r			•					
Check all that apply	•							
<ul> <li>You will be under 1</li> </ul>		at the start	of your first se	mester				
<ul> <li>This will be your fir</li> </ul>	-		-		nous housing reg	ardless of your a	17e	
(A transfer or gradua								
You have one or me								or complement
inhibitor use, HIV		0	·	,	, 0	, ,	,	·
□ You are a traveler t	o/resident o	f areas with	endemic mer	ningitis				
If you checked any o	of the boxe	s above, y	ou must rece	eive at leas	t one dose of a	n approved Me	eningitis ACYW.	
Meningitis ACYW	Vaccine		Date (mm/d		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		sessmen	L					
Check all that apply				aia aialda ad	I N as a sin site			
You have one or me inhibitor use UNV	ore of the fo	nowing con	ditions: aspier	hia, sickle ce	eii, N. meningitia	is lab work, comp	plement denciency	or complement
inhibitor use, HIV <ul> <li>You are a traveler t</li> </ul>	o/rocidont o	faraacwitk	andomic mo	ningitic				
						ion Doonioo		
If you checked any o		s above, y						
Meningitis B	Vaccine	ne Date (mm/dd/yyyy) Manufacturer						
	Men B dos	se 1	//		🗆 Trumenba		Bexsero	
	Men B dos	se 2	/	_/	🗆 Trumenba		🗆 Bexsero	
	Men B dos	se 3	//					
Please tell			ed the follow	wing vacc		ly recommend	led but not requ	uired.
Vaccine		Date (mn	n/dd/yyyy)	Manufac	turer			
Human Papilloma V	ïrus	/	/	Gardas		sil 9 🗆 Cerva	rix 🗆 Unknow	n
•		/		🗆 Gardas	il 4 🗆 Gardas	sil 9 🗆 Cerva	rix 🗆 Unknow	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)

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:		