RUTGERS

This form is for clinical students

Immunization Packet - 4 steps

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

1 **Fill out the Mandatory Health Questionnaire**

2 **Ask your healthcare provider to fill out this Immunization Packet**

Some of your vaccines may have already transferred into our system from the NJ vaccine registry or your previous time at Rutgers. To check your vaccine record, PRINT your record from the Immunization tab.
Please do not re-submit immunizations that are already in the system.

3 **Enter the dates of your vaccines or labs under the Immunization tab**

4 **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			
Hep B antibody test To satisfy the requirement, you must provide 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 provide a Hep B surface antigen and restart the series)* □ Non-responder *(after 2 complete series)*
Hep B surface antigen *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

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If you are not immune to Hepatitis B, you have 2 options: (1) receive a booster dose & recheck your immunity OR (2) complete the series & recheck your immunity. Immunity can be checked 4-6 weeks after a vaccine dose.

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	

Repeat Hepatitis B series *Only if not immune after primary series, receive booster dose OR complete series before rechecking for immunity.*	**Vaccine**	**Date** *(mm/dd/yyyy)*	**Manufacturer**		
	Hep B dose 4	____/____/____	□ Engerix	□ Twinrix	□ Heplisav
	Hep B dose 5	____/____/____	□ Engerix	□ Twinrix	□ Heplisav
	Hep B dose 6	____/____/____	□ Engerix	□ Twinrix	

Student MUST submit a Quantitative Hep B Surface Antibody that demonstrates immunity to fulfill the requirement. Immunity can be checked 4-6 weeks after a vaccine dose.	**Quantitative Hep B Surface Antibody Test**
	____/____/____ □ Immune (≥10 mIU/mL) □ Non-immune

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 provide 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** *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

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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 provide 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

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 The most recent dose must be on or after your 16th birthday.	**Vaccine**	**Date** *(mm/dd/yyyy)*	**Manufacturer**
	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 B vaccination 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

Indicate if you have received the following vaccine. It is highly recommended but not required.

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

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Indicate 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	____/____/____	

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