RUTGERS

This form is for clinical students

# Immunization Packet - 4 steps

**All forms and uploads must be completed at https://rbhs.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

**Questions? Send us a secure message through the portal at https://rbhs.medicatconnect.com**

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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**<br>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**<br>To satisfy this option, blood tests must demonstrate immunity to measles, mumps, and rubella.<br>***LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED TO THE PORTAL*** | 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.**<br>Doses may be entered individually in this section.<br>*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**<br>To satisfy the requirement, you must provide a QUANTITATIVE Hep B surface antibody test showing immunity to Hepatitis B.<br>***LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED TO THE PORTAL*** | **Test** | **Date** *(mm/dd/yyyy)* | **Lab Results** |
| | Quantitative Hep B surface antibody | ____/____/____ | □ Immune (≥10 mIU/mL)<br>□ Non-immune *(If you are non-immune you must provide a Hep B surface antigen and restart the series)*<br>□ Non-responder *(after 2 complete series)* |
| **Hep B surface antigen**<br>*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** | **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 demonstrate immunity to fulfill the requirement.** *Immunity can be checked 4-6 weeks after a vaccine dose.* ***LAB REPORT(S) MUST BE UPLOADED TO THE PORTAL*** | **Quantitative Hep B surface antibody** ____/____/____ □ 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 UPLOADED TO THE PORTAL***
*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 uploaded to the portal.***

**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**<br>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**<br>To satisfy this option, you must provide a blood test demonstrating immunity to varicella.<br>***LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT*** | Varicella titer | ____/____/____ | □ Immune □ Non-Immune<br>□ 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** | **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 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** | ____/____/____<br>____/____/____<br>____/____/____ | |
| **Typhoid** *(most recent dose)* | ____/____/____ | □ TyphIM □ Vivotif |
| **Yellow Fever** | ____/____/____ | |