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 (Category 2) immunization requirements apply to students who will see patients or clients during the course of their program but have no risk of exposure to blood or infectious body fluids. Not sure of your category? Reach out to your program.

Required:
Measles Mumps Rubella
Hepatitis B
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 second dose at least 28 days after.	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 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. 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	**Test**	**Date** *(mm/dd/yyyy)*	**Lab Results**
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 TO THE PORTAL***	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

RUTGERS

Healthcare Provider Initials	

Last name __________________ First name _________________ DOB *(mm/dd/yyyy)* _________ RUID or A number _____________

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	**Vaccine**	**Date** *(mm/dd/yyyy)*	**Manufacturer**		
*Only if not immune after primary series, receive booster dose OR complete series before rechecking for immunity.***	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

Updated: 3.2025

RUTGERS

Healthcare Provider Initials	

Last name __________________ First name _________________ DOB *(mm/dd/yyyy)* _________ RUID or A number _____________

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	**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

Updated: 3.2025

RUTGERS

Healthcare Provider Initials	

Last name ________________ First name ______________ DOB *(mm/dd/yyyy)* ________ RUID or A number __________

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	____/____/____	