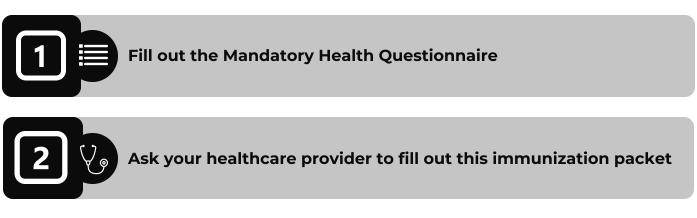


Immunization Packet - 4 steps

All forms and uploads must be completed at <u>https://patient-rbhs.medicatconnect.com</u>



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.



Enter the dates of your vaccines or labs under the immunization tab



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

<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):	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 To satisfy this option, blood tests must	Measles (Rubeola) 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				
Option C: Measles, Mumps and Rubella	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	Vaccino		Date (mm/dd/yyyy)	Manufacturer		
If starting the series, at least one dose is	dose is Hep B dos			Engerix		Heplisav
required prior to enrollment.						-
	Hep B dos		//	Engerix		Heplisav
	Hep B dos	e 3	/	Engerix	🗆 Twinrix	
Adult Tdap (Tetanus, Diphtheria & Acellul	ar Pertussis)		//	Adacel	🗆 Boostrix	(
Annual Influenza – List vaccination for th	e current flu seasc	on	//			
Tuberculosis (TB) Screening – Complete	ontion 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	2 / /	 /		
and read 48-72 hours after placement) wi	•	PPD	Z //	/	/	mm
months of your enrollment date.		Both	n tests must be < 10mm.			
If PPD is positive (≥ 10mm), is the student free of TB sy If yes, list date of the positive PPD and induration. Was the student treated? □Yes □No If yes, for how long was the student treated and wi <u>If PPD is positive</u> : option B or a chest x-ray** must B 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. <u>Lab report must be attached.</u> <u>If your TB Blood test result is positive</u> , a chest x-ray** must be completed.			/, n hpleted. h od test e:// e: □ QuantiFERON Gold b Report attached		legative □	Positive
**Chest x-ray result		Chest x-ray				
If you did NOT have a positive PPD or	•	Date://				
test, do NOT complete this option.		Normal Abnormal Demont attacked				
To complete this option a chest x-ray w	•	Report attached				
months must be normal , and report must be attached.						
Varicella (Chicken Pox) – Complete option A or B to fulfill this requirement						
Option A: Varicella vaccine dosesVaccineFirst dose on or after your first birthday and a second dose at least 28 days apartVaricella dose 1Varicella dose 2Varicella dose 2			Date (mm/dd/yyyy)	Result		
			//			
			//			
Option B: Varicella serologic immunity To satisfy this option, you must submit a						

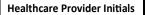
___/___/___

Varicella titer

Category 2 Immunization Packet | 2

□ Immune □ Non-Immune

□ Lab Report attached



R	RUTGERS
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Last name		First name	e C		DOB (mm/dd/yyyy)		RUID or A number	
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 r	equiremen	t assessm	ent					
Check all that apply	below.							
You will be under 19 years old at the start of your first semester								
This will be your fir	st year in an	y college an	d you will be	living in can	npus housing, reg	gardless of your a	ige	
(A transfer or gradua								
You have one or me	ore of the fo	llowing con	ditions: aspler	nia, sickle ce	ell, N. meningitid	is lab work, com	plement deficiency	or complement
inhibitor use, HIV								
You are a traveler t				-				
If you checked any o	of the boxe	s above, y	ou must rece	eive at leas			eningitis ACYW.	
Meningitis ACYW	Vaccine		Date (mm/	′dd/yyyy)	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					MenQuadfi
Meningitis B requi	irement as	sessmen	t					
Check all that apply								
□ You have one or m		llowing con	ditions: aspler	nia. sickle ce	ell. N. meningitid	is lab work. com	plement deficiency	or complement
inhibitor use, HIV		- 0		-,	, - 0	,		
□ You are a traveler t	o/resident o	f areas with	n endemic mer	ningitis				
If you checked any o					ingitis vaccinat	ion B series.		
Meningitis B	Vaccine		Date (mm/		Manufacturer			
-	Men B dos	se 1	/	/	🗆 Trumenba		Bexsero	
	Men B dos	se 2	/	/				
	Men B dos	se 3	/	// 🗆 Trumenba				
Please tell us if you've received the following vaccine. It is highly recommended but not required.								
Vaccine		Date (m	m/dd/yyyy)	Manufac	turer			
Human Papilloma V	'irus	Ì_	/	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	//		