




Immunization Packet Instructions

All forms and uploads must be completed at <https://redcap.link/2y54qcyh>

1  Ask your healthcare provider to fill out this immunization packet

2  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

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 (<i>print</i>): | Date | Practice stamp |
| Healthcare provider name (<i>sign</i>): | | |
| 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 (<i>Rubeola</i>) titer | ___/___/___ | <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune |
| | Mumps titer | ___/___/___ | <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune |
| | Rubella titer | ___/___/___ | <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune |
| Option C: Measles, Mumps and Rubella immunizations if given separately. Doses may be entered individually in this section. <i>DO NOT RE-ENTER DOSES IF LISTED ABOVE</i> | 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 | ___/___/___ | <input type="checkbox"/> Immune (≥10 mIU/mL) <input type="checkbox"/> Non-immune (<i>If you are non-immune you must provide a Hep B surface antigen and restart the series</i>) <input type="checkbox"/> Non-responder (<i>after 2 complete series</i>) |
| | Hep B surface antigen <i>We recommend submitting a Hep B surface antigen in case the quantitative Hep B surface antibody does not demonstrate immunity.</i> | Hep B surface antigen | ___/___/___ |

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 If starting the series, at least one dose is required prior to enrollment. | Vaccine | Date (mm/dd/yyyy) | Manufacturer | | |
|--|--------------|-------------------|----------------------------------|----------------------------------|-----------------------------------|
| | Hep B dose 1 | ___/___/___ | <input type="checkbox"/> Engerix | <input type="checkbox"/> Twinrix | <input type="checkbox"/> Heplisav |
| | Hep B dose 2 | ___/___/___ | <input type="checkbox"/> Engerix | <input type="checkbox"/> Twinrix | <input type="checkbox"/> Heplisav |
| | Hep B dose 3 | ___/___/___ | <input type="checkbox"/> Engerix | <input type="checkbox"/> Twinrix | |

| Repeat Hepatitis B series <i>Only if not immune after primary series, receive booster dose OR complete series before rechecking for immunity.**</i> | Vaccine | Date (mm/dd/yyyy) | Manufacturer | | |
|---|--------------|-------------------|----------------------------------|----------------------------------|-----------------------------------|
| | Hep B dose 4 | ___/___/___ | <input type="checkbox"/> Engerix | <input type="checkbox"/> Twinrix | <input type="checkbox"/> Heplisav |
| | Hep B dose 5 | ___/___/___ | <input type="checkbox"/> Engerix | <input type="checkbox"/> Twinrix | <input type="checkbox"/> Heplisav |
| | Hep B dose 6 | ___/___/___ | <input type="checkbox"/> Engerix | <input type="checkbox"/> Twinrix | |

| **Student MUST demonstrate immunity to fulfill the requirement. Immunity can be checked 4-6 weeks after a vaccine dose. <u>LAB REPORT(S) MUST BE UPLOADED TO THE PORTAL</u> | <u>Quantitative Hep B surface antibody</u> | | |
|---|--|---|--|
| | ___/___/___ | <input type="checkbox"/> Immune (≥10 mIU/mL) <input type="checkbox"/> Non-immune | |

| | | |
|---|-------------|---|
| Adult Tdap (Tetanus, Diphtheria & Acellular Pertussis) | ___/___/___ | <input type="checkbox"/> Adacel <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list date of the positive PPD and induration. ___/___/___, ___ mm Was the student treated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long was the student treated and with which medication? _____ <i>If PPD is positive: option B or a chest x-ray** must be completed.</i> |
|--|

| | |
|--|--|
| 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. <u>LAB REPORT MUST BE UPLOADED TO THE PORTAL</u> <i>If your TB Blood test result is positive, a chest x-ray** must be completed.</i> | Blood test Date: ___/___/___ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Type: <input type="checkbox"/> QuantiFeron Gold <input type="checkbox"/> T-Spot <input type="checkbox"/> Lab report attached |
|--|--|

| | |
|--|--|
| **Chest x-ray result <i>To complete this option a chest x-ray within the past 6 months must be <u>normal</u> and <u>report must be uploaded to the portal.</u></i> | Chest x-ray Date: ___/___/___ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____ <input type="checkbox"/> Report attached |
|--|--|

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 | Vaccine | Date (mm/dd/yyyy) | Result |
|--|------------------------|-------------------|---|
| First dose on or after your first birthday and a second dose at least 28 days apart | 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 | ___/___/___ | <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> 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 | ___/___/___ | <input type="checkbox"/> Menveo <input type="checkbox"/> Menactra <input type="checkbox"/> Menomune <input type="checkbox"/> MenQuadfi |
| | Men ACYW dose 2 | ___/___/___ | <input type="checkbox"/> Menveo <input type="checkbox"/> Menactra <input type="checkbox"/> Menomune <input type="checkbox"/> 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 | ___/___/___ | <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero |
| | Men B dose 2 | ___/___/___ | <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero |
| | Men B dose 3 | ___/___/___ | <input type="checkbox"/> 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) | ___/___/___ | <input type="checkbox"/> Gardasil 4 | <input type="checkbox"/> Gardasil 9 | <input type="checkbox"/> Cervarix | <input type="checkbox"/> Unknown |
| | ___/___/___ | <input type="checkbox"/> Gardasil 4 | <input type="checkbox"/> Gardasil 9 | <input type="checkbox"/> Cervarix | <input type="checkbox"/> Unknown |
| | ___/___/___ | <input type="checkbox"/> Gardasil 4 | <input type="checkbox"/> Gardasil 9 | <input type="checkbox"/> Cervarix | <input type="checkbox"/> Unknown |

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) | ___/___/___ | <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Other _____ |
| Hepatitis A | ___/___/___ | |
| Japanese Encephalitis | ___/___/___ | |
| Pneumococcal | ___/___/___ | <input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23 |
| | ___/___/___ | <input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23 |
| | ___/___/___ | <input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23 |
| | ___/___/___ | <input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23 |
| Polio Booster | ___/___/___ | |
| Rabies | ___/___/___ | |
| | ___/___/___ | |
| | ___/___/___ | |
| Typhoid (most recent dose) | ___/___/___ | <input type="checkbox"/> TyphIM <input type="checkbox"/> Vivotif |
| Yellow Fever | ___/___/___ | |