




# Immunization Packet Instructions

This form is for the following Nursing Continuing Education programs **ONLY**:

- RN Skill Refresher (RNF)
- Operating Room Nurse (OR)

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
- Physical exam

**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	___/___/___	
<b>Option B: MMR serological immunity</b> To satisfy this option, blood tests must demonstrate immunity to measles, mumps, and rubella. <b>LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED TO THE PORTAL</b>	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
<b>Option C: Measles, Mumps and Rubella immunizations if given separately.</b> 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. <b>LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED TO THE PORTAL</b>	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> )
<b>Hep B surface antigen</b> <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	___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Positive

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.

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

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

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

<b>Adult Tdap (Tetanus, Diphtheria &amp; Acellular Pertussis)</b>	___/___/___	<input type="checkbox"/> Adacel <input type="checkbox"/> Boostrix
---	-------------	---

<b>Annual Influenza – List vaccination for the current flu season</b>	___/___/___
---	-------------

**Tuberculosis (TB) Screening – Complete option A or B to fulfill this requirement**

<b>Option A: PPD (Mantoux) skin tests</b> <i>Required regardless of prior BCG vaccination.</i> 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.	<b>PPD placed</b>	<b>PPD read</b>	<b>Induration</b>
	PPD 1 ___/___/___	___/___/___	___ mm
	PPD 2 ___/___/___	___/___/___	___ mm
	<b>Both tests must be &lt; 10mm.</b>		

**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.*

<b>Option B: FDA approved blood test</b> 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. <b><u>LAB REPORT MUST BE UPLOADED TO THE PORTAL</u></b> <i>If your TB Blood test result is positive, a chest x-ray** must be completed.</i>	<b>Blood test</b>
	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

<b>**Chest x-ray result</b> <i>To complete this option a chest x-ray within the past 6 months must be <b>normal</b> and <b>report must be uploaded to the portal.</b></i>	<b>Chest x-ray</b> 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	___/___/___	
<b>Option B: Varicella serologic immunity</b> To satisfy this option, you must provide a blood test demonstrating immunity to varicella. <b>LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT</b>	<b>Varicella titer</b>	___/___/___	<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			
<b>Human Papilloma Virus (HPV)</b>	___/___/___	<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)	
<b>COVID-19</b> (most recent dose)	___/___/___	<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Other _____
<b>Hepatitis A</b>	___/___/___	
<b>Japanese Encephalitis</b>	___/___/___	
<b>Pneumococcal</b>	___/___/___	<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
<b>Polio Booster</b>	___/___/___	
<b>Rabies</b>	___/___/___	
	___/___/___	
	___/___/___	
<b>Typhoid</b> (most recent dose)	___/___/___	<input type="checkbox"/> TyphIM <input type="checkbox"/> Vivotif
<b>Yellow Fever</b>	___/___/___	

### Physical Examination Form

Your healthcare provider may supply their own physical form/document, which you may upload as documentation of your physical exam in lieu of using this form.

**Part I: Student to complete (please print or type)**

Last name _____	First name _____	DOB (mm/dd/yyyy) _____
RUID or A number _____	Email _____	Cell phone _____
School/Program _____	Grad year _____	

**Part II: To be completed by the healthcare provider**  
*Physical exam must be completed by a non-relative physician, nurse practitioner, or physician's assistant*

Exam Date: _____			
Height (inches): _____		Weight (pounds): _____	
BMI: _____		BP: _____	Pulse: _____
	Normal	Abnormal	If abnormal, please explain:
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Exam	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Exam	<input type="checkbox"/>	<input type="checkbox"/>	_____

Healthcare provider name ( <i>print</i> ): _____	Date: _____	Practice stamp
Healthcare provider name ( <i>sign</i> ): _____		
NPI: _____		