





Immunization Packet - 4 steps


All forms and uploads must be completed at <https://patient-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:

COVID-19: updated COVID vaccine or original booster dose
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





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Questions?
Log in and send us a secure message.

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 _____

Healthcare provider to complete (please print or type)

Measles, Mumps, Rubella (MMR) – Complete option A, B, or C to fulfill this requirement			
Option A: MMR vaccine doses 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 To satisfy this option, blood tests must demonstrate immunity to measles, mumps, and rubella. LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT	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 – Complete Section A and B			
Section A: Hep B antibody test To satisfy the requirement, you must supply a QUANTITATIVE Hep B Surface Antibody test showing immunity to Hepatitis B. LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT	Test	Date (mm/dd/yyyy)	Lab Results
	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 complete the Hepatitis B surface antigen test**</i>) <input type="checkbox"/> Lab Report Attached
**Hep B surface antigen test <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 <input type="checkbox"/> Lab Report Attached
Section B: 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"/> 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

COVID-19 - 1 updated COVID-19 vaccine OR a primary series with a booster dose			
All doses must be FDA or WHO-approved.	Vaccine	Date (mm/dd/yyyy)	Manufacturer
	Dose 1	____/____/____	
	Dose 2	____/____/____	
	Most recent booster	____/____/____	



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Adult Tdap (Tetanus, Diphtheria & Acellular Pertussis)	____/____/____	<input type="checkbox"/> Adacel <input type="checkbox"/> Boostrix
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Annual Influenza – List vaccination for the current flu season	____/____/____
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Tuberculosis (TB) Screening – Complete option A or B to fulfill this requirement

<p>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.</p>	<table style="width:100%"> <tr> <td></td> <td style="text-align:center">PPD placed</td> <td style="text-align:center">PPD read</td> <td style="text-align:center">Induration</td> </tr> <tr> <td>PPD 1</td> <td>____/____/____</td> <td>____/____/____</td> <td>____ mm</td> </tr> <tr> <td>PPD 2</td> <td>____/____/____</td> <td>____/____/____</td> <td>____ mm</td> </tr> </table> <p>Both tests must be < 10mm.</p>		PPD placed	PPD read	Induration	PPD 1	____/____/____	____/____/____	____ mm	PPD 2	____/____/____	____/____/____	____ mm
	PPD placed	PPD read	Induration										
PPD 1	____/____/____	____/____/____	____ mm										
PPD 2	____/____/____	____/____/____	____ mm										

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.*

<p>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. Lab report must be attached. <i>If your TB Blood test result is positive, a chest x-ray** must be completed.</i></p>	<p>Blood test Date: ____/____/____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Type: <input type="checkbox"/> QuantiFERON Gold <input type="checkbox"/> T-Spot</p> <p><input type="checkbox"/> Lab Report attached</p>
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<p>**Chest x-ray result If you did NOT have a positive PPD or positive blood test, do NOT complete this option. <i>To complete this option a chest x-ray within the past 6 months must be <u>normal</u>, and <u>report must be attached</u>.</i></p>	<p>Chest x-ray Date: ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____ <input type="checkbox"/> Report attached</p>
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Varicella (Chicken Pox) – Complete option A or B to fulfill this requirement

Option A: Varicella vaccine doses	Vaccine/Titer	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	____/____/____	
<p>Option B: Varicella serologic immunity To satisfy this option, you must submit a blood test demonstrating immunity to varicella. LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT</p>	Varicella titer	____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Lab Report attached



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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 vaccination B 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 <i>(either a 2 or 3 dose series)</i>	

Please tell us if you've received the following vaccine. It is highly recommended but not required.

Vaccine	Date (mm/dd/yyyy)	Manufacturer			
Human Papilloma Virus	___/___/___	<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

Please tell us about additional vaccinations you may have received.

Vaccine	Date (mm/dd/yyyy)	Other Details
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



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Polio Booster	____/____/____	
Rabies	____/____/____	
	____/____/____	
	____/____/____	
Typhoid (most recent dose)	____/____/____	<input type="checkbox"/> TyphIM <input type="checkbox"/> Vivotif
Yellow Fever	____/____/____	

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