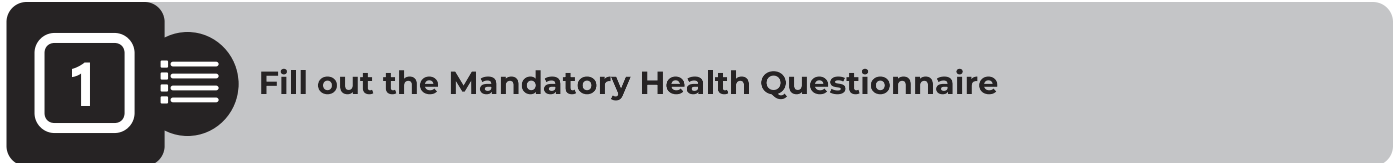
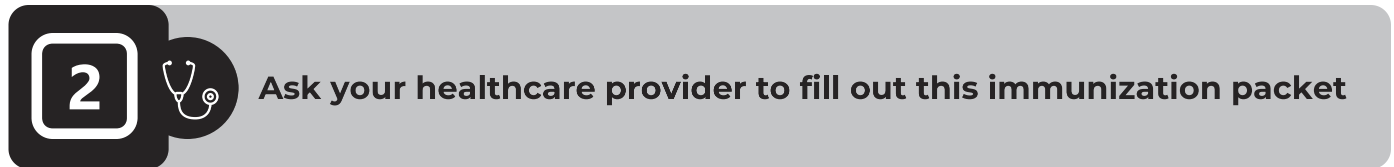
RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

This form is for clinical students

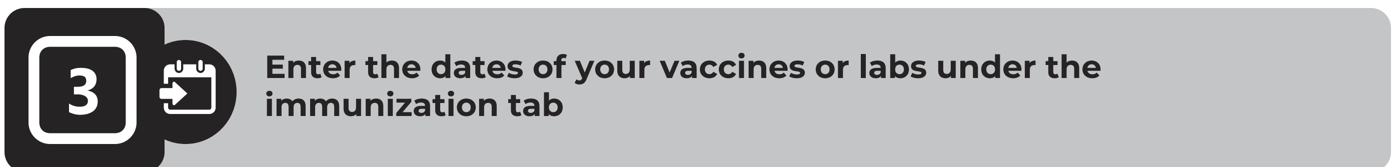
Immunization Packet - 4 steps

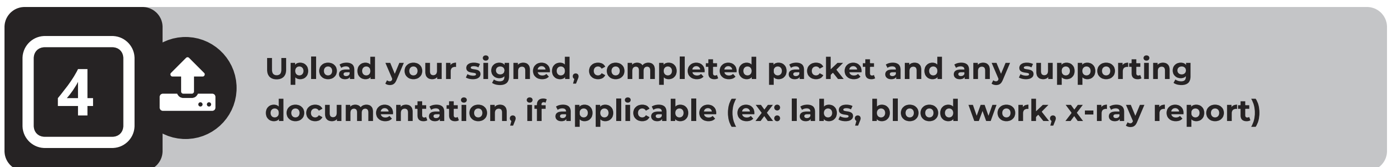
All forms and uploads must be completed at https://patient-rbhs.medicatconnect.com





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.





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

Questions? Send us a secure message through the portal at https://patient-rbhs.medicatconnect.com

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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*

	Vaccine/Titer	Date *(mm/dd/yyyy)*	Result
Option A: MMR vaccine doses 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 AS AN ATTACHMENT**	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 – *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 QUANTITATIVE Hep B Surface Antibody test showing immunity to Hepatitis B. ***LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT***	Quantitative Hep B surface antibody	_____/_____/_____	☐ Immune (≥10 mIU/mL) ☐ Non-immune *(If you are non-immune you must complete the Hepatitis B surface antigen test**)* ☐ Lab Report Attached
****Hep B surface antigen test** *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 ☐ Lab Report Attached
Section B: Hep B vaccine doses	**Vaccine**	**Date** (mm/dd/yyyy)	**Manufacturer**
If starting the series, at least one dose is required prior to enrollment.	Hep B dose 1	_____/_____/_____	☐ Engerix ☐ Twinrix ☐ Heplisav
	Hep B dose 2	_____/_____/_____	☐ Engerix ☐ Twinrix ☐ Heplisav
	Hep B dose 3	_____/_____/_____	☐ Engerix ☐ 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)*	_____/_____/_____	☐ 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 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.** *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** **If you did NOT have a positive PPD or positive blood test, do NOT complete this option.** *To complete this option a chest x-ray within the past 6 months must be **normal**, and **report must be attached.***	**Chest x-ray** Date: _____/_____/_____ ☐ Normal ☐ Abnormal ___________________________ ☐ Report attached

Varicella (Chicken Pox) – *Complete option A or B to fulfill this requirement*

	Vaccine/Titer	**Date** (mm/dd/yyyy)	**Result**
Option A: Varicella vaccine doses 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 submit 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

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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	_____/_____/_____	☐ 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 vaccination B 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 ***(either a 2 or 3 dose series)***	

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	_____/_____/_____	☐ Gardasil 4	☐ Gardasil 9	☐ Cervarix	☐ Unknown
	_____/_____/_____	☐ Gardasil 4	☐ Gardasil 9	☐ Cervarix	☐ Unknown
	_____/_____/_____	☐ Gardasil 4	☐ Gardasil 9	☐ Cervarix	☐ Unknown

Please tell us about additional vaccinations you may have received.

Vaccine	**Date** *(mm/dd/yyyy)*	**Other Details**	
Hepatitis A	_____/_____/_____		
	_____/_____/_____		
Japanese Encephalitis	_____/_____/_____		
	_____/_____/_____		
Pneumococcal	_____/_____/_____	☐ PCV13	☐ PPSV23
	_____/_____/_____	☐ PCV13	☐ PPSV23
	_____/_____/_____	☐ PCV13	☐ PPSV23
	_____/_____/_____	☐ PCV13	☐ PPSV23

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Polio Booster	____/____/____	
Rabies	____/____/____ ____/____/____ ____/____/____	
Typhoid *(most recent dose)*	____/____/____	☐ TyphIM ☐ Vivotif
Yellow Fever	____/____/____	

Healthcare provider name *(print)*: *(sign)*:	Date	Practice stamp
NPI:		

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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.

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	_____________

Physical Form: 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	☐	☐	____________________
Skin	☐	☐	____________________
Head	☐	☐	____________________
Eyes	☐	☐	____________________
Neurological Exam	☐	☐	____________________
Respiratory	☐	☐	____________________
Psychiatric Exam	☐	☐	____________________

Healthcare provider name *(print)*:	*(sign)*:	Date	Practice stamp
NPI:			