




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)

Non-clinical student immunization requirements

Required:

Measles Mumps Rubella

Hepatitis B

COVID-19: primary series or 1 updated COVID 19 vaccine

May be required (see immunization form for details):

Meningitis ACYW

Meningitis B

Tuberculosis screening

Non-clinical students, 31 and over, are exempt from MMR & Hep B requirements.





Use your Rutgers login to upload this completed and signed form into <https://patient-rbhs.medicatconnect.com/>

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 option A or B to fulfill this requirement			
Option A: 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
Option B: Hep B antibody Test To satisfy the option, 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	Antibody Test	Date (mm/dd/yyyy)	Lab Results
	Quantitative Hepatitis B Surface Antibody	____/____/____	<input type="checkbox"/> Immune (≥10 mIU/mL) <input type="checkbox"/> Non-immune <input type="checkbox"/> Lab Report Attached

COVID-19 – A primary series or updated COVID-19 vaccine			
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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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>	

Tuberculosis – TB screening is required for students who meet the criteria below. Please complete the assessment to determine your requirement.

Check all that apply below.

- Had close contact with persons known or suspected to have active TB disease?
- Spent more than one month OR was born in:
Afghanistan, Algeria, Angola, Anguilla, Argentina, Armenia, Azerbaijan, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Burkina Faso, Burundi, Côte d'Ivoire, Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, China, Colombia, Comoros, Congo, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Fiji, Gabon, Gambia, Georgia, Ghana, Greenland, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho, Liberia, Libya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mexico, Micronesia (Federated States of), Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue, Northern Mariana Islands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Tajikistan, Thailand, Timor-Leste, Togo, Tokelau, Tunisia, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe
- Lived in or been employed by a correctional facility, long-term care facility, or homeless shelter?
- Volunteered or worked with clients/patients at increased risk for active TB disease?

If you checked any of the boxes above, you must submit TB test results within the past 6 months of your enrollment date.



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Last name _____ First name _____ DOB (mm/dd/yyyy) _____ RUID or A number _____

Complete option A or B to fulfill this requirement.

Option A: PPD (Mantoux) skin test

To satisfy this option, a PPD (*must be read 48-72 hours after placement*) within the past 6 months of your enrollment date. The test must be < 10mm.
If your PPD is positive, option B or a chest x-ray must be completed.

Results

PPD Placed: ___/___/___
PPD read: ___/___/___ Induration _____ mm
Result: Negative Positive

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: Neg Pos
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 of your enrollment date, must be normal, and report must be attached.

Chest x-ray

Date: ___/___/___
 Normal Abnormal _____
 Report Attached

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
Adult Tdap	___/___/___	<input type="checkbox"/> Tdap <input type="checkbox"/> Td
Varicella (<i>Chicken Pox</i>)	___/___/___ ___/___/___	Or varicella serologic immunity (list date and attach lab report) Date: ___/___/___ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
Annual flu (<i>for current flu season</i>)	___/___/___	
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 (<i>most recent dose</i>)	___/___/___	<input type="checkbox"/> TyphIM <input type="checkbox"/> Vivotif
Yellow Fever	___/___/___	

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