RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

This form is for visiting and continuing education students in clinical programs

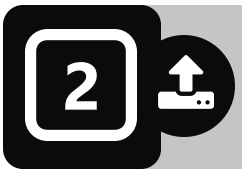
Immunization Packet Instructions

This form is for the following Dental Continuing Education programs ONLY:

- **Dental Visiting (SDM/VISIT)**
- **Dental Maxi Program**
- **Continuing Dental Clinical Preceptorship**

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

Ask your healthcare provider to fill out this immunization packet



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

Questions? Contact the Student Health line at RBHS-Newark: 973-972-7687

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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 *(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 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	_____/_____/_____	□ 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 If starting the series, at least one dose is required prior to enrollment.	**Vaccine**	**Date** (mm/dd/yyyy)	**Manufacturer**
	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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Last name _____ First name _____ DOB (mm/dd/yyyy) _____ RUID or A number _____

Adult Tdap *(Tetanus, Diphtheria & Acellular Pertusis)*	_____/_____/_____	□ 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. Both tests must be < 10mm.

	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.

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*

Option A: Varicella vaccine doses First dose on or after your first birthday and a second dose at least 28 days apart	**Vaccine/Titer**	**Date** (mm/dd/yyyy)	**Result**
	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

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