



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/f6vn68p5>



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:

Measles, Mumps, and 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

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	___/___/___	
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 TO THE PORTAL	Measles (<i>Rubeola</i>) 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. <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. LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED TO THE PORTAL	Quantitative Hep B surface antibody	___/___/___	☐ Immune (≥10 mIU/mL) ☐ Non-immune (<i>If you are non-immune you must provide a Hep B surface antigen and restart the series</i>) ☐ Non-responder (<i>after 2 complete series</i>)
	Hep B surface antigen	___/___/___	☐ Negative ☐ 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.

Hep B vaccine doses	Vaccine	Date (mm/dd/yyyy)	Manufacturer
	Hep B dose 1	___/___/___	☐ Enderix ☐ Twinrix ☐ Heplisav
	Hep B dose 2	___/___/___	☐ Enderix ☐ Twinrix ☐ Heplisav
	Hep B dose 3	___/___/___	☐ Enderix ☐ Twinrix

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

**Student MUST demonstrate immunity to fulfill the requirement. Immunity can be checked 4-6 weeks after a vaccine dose. <u>LAB REPORT(S) MUST BE UPLOADED TO THE PORTAL</u>	<u>Quantitative Hep B surface antibody</u> ___/___/___ ☐ Immune (≥10 mIU/mL) ☐ Non-immune
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Adult Tdap (Tetanus, Diphtheria & Acellular Pertussis)	___/___/___	☐ Adacel ☐ 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															
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.		<table border="1"> <thead> <tr> <th></th> <th>PPD placed</th> <th>PPD read</th> <th>Induration</th> </tr> </thead> <tbody> <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> </tbody> </table> Both tests must be < 10mm.			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? _____ <u>If PPD is positive: option B or a chest x-ray** must be completed.</u>															
Option B: FDA approved blood test 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. <u>LAB REPORT MUST BE UPLOADED TO THE PORTAL</u> <u>If your TB Blood test result is positive, a chest x-ray** must be completed.</u>		Blood test Date: ___/___/___ Result: ☐ Negative ☐ Positive Type: ☐ QuantiFeron Gold ☐ T-Spot ☐ Lab report attached													
**Chest x-ray result To complete this option a chest x-ray within the past 6 months must be <u>normal</u> and <u>report must be uploaded to the portal.</u>		Chest x-ray Date: ___/___/___ ☐ Normal ☐ Abnormal _____ ☐ 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	____/____/____	
Option B: Varicella serologic immunity To satisfy this option, you must provide 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

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 B vaccination 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

Indicate if you have received the following vaccine. It is highly recommended but not required.

Vaccine	Date (mm/dd/yyyy)	Manufacturer
Human Papilloma Virus (HPV)	____/____/____	☐ Gardasil 4 ☐ Gardasil 9 ☐ Cervarix ☐ Unknown
	____/____/____	☐ Gardasil 4 ☐ Gardasil 9 ☐ Cervarix ☐ Unknown
	____/____/____	☐ Gardasil 4 ☐ Gardasil 9 ☐ Cervarix ☐ 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)	
COVID-19 (most recent dose)	___/___/___	☐ Pfizer ☐ Moderna ☐ Novavax ☐ Other _____
Hepatitis A	___/___/___	
Japanese Encephalitis	___/___/___	
Pneumococcal	___/___/___	☐ PCV13 ☐ PPSV23
	___/___/___	☐ PCV13 ☐ PPSV23
	___/___/___	☐ PCV13 ☐ PPSV23
	___/___/___	☐ PCV13 ☐ PPSV23
Polio Booster	___/___/___	
Rabies	___/___/___	
	___/___/___	
	___/___/___	
Typhoid (most recent dose)	___/___/___	☐ TyphIM ☐ Vivotif
Yellow Fever	___/___/___	