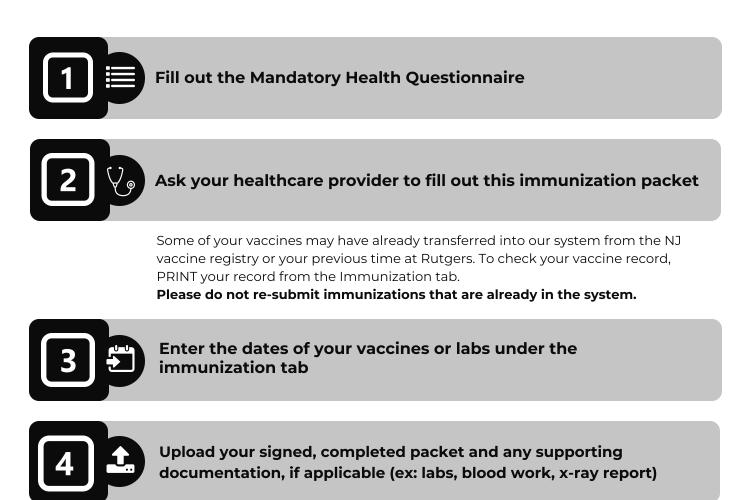


Immunization Packet - 4 steps

All forms and uploads must be completed at https://rutgers.medicatconnect.com



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 Rubella Hepatitis B, including labs for immunity Adult Tdap Tuberculosis screening Varicella Annual flu Physical Exam <u>May be required (see immunization form for details):</u> Meningitis ACYW Meningitis B





Use your Rutgers login to upload this completed and signed form into https://rutgers.medicatconnect.com/

Questions? Log in and send us a secure message.

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 (print):	Practice stamp
Healthcare provider name (sign):	
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	MMR dose 1	//					
second dose at least 28 days after.	MMR dose 2	//					
Option B: MMR serological immunity	Measles (Rubeola)						
To satisfy this option, blood tests must	titer	//	🗆 Immune 🛛 Non-Immune				
demonstrate immunity to measles, mumps,							
and rubella.	Mumps titer	//	🗆 Immune 🛛 🗆 Non-Immune				
LAB REPORTS ARE REQUIRED AND MUST BE							
UPLOADED AS AN ATTACHMENT	Rubella titer	//	🗆 Immune 🛛 🗆 Non-Immune				
Option C: Measles, Mumps and Rubella	Measles dose 1	//					
immunizations if given separately. Doses may be entered individually in this	Measles dose 2	//					
section.	Mumps dose 1	//					
	Mumps dose 2	//					
DO NOT RE-ENTER DOSES IF LISTED ABOVE	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	<u>Quantitative</u>		□ Immune (≥10 mIU/mL)				
QUANTITATIVE Hep B Surface Antibody test	Hep B surface	//	Non-immune (If you are non-				
showing immunity to Hepatitis B.	antibody		immune you must complete the				
LAB REPORTS ARE REQUIRED AND MUST BE			Hepatitis B surface antigen test**)				
UPLOADED AS AN ATTACHMENT			Lab Report Attached				
**Hep B surface antigen test							
We recommend submitting a Hep B Surface	Hep B surface		Negative Positive				
Antigen in case the quantitative Hep B	antigen	//					
Surface Antibody does not demonstrate			Lab Report Attached				
immunity.							



blood test demonstrating immunity to

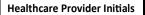
LAB REPORTS ARE REQUIRED AND

MUST BE UPLOADED AS AN

varicella.

ATTACHMENT

Last name First name		_ D	OB (mm/dd/yyyy)	RUID	or A number	
Section B: Hep B vaccine doses	ction B: Hep B vaccine doses Vaccine		Date (mm/dd/yyyy)	Manufacturer		
If starting the series, at least one dose is				Engerix		Heplisav
required prior to enrollment.	Hep B dos					-
	•			🗆 Engerix		Heplisav
	Hep B dos	ie 3	/	Engerix		
Adult Tdap (Tetanus, Diphtheria & Acellul	ar Pertussis)		//	Adacel	Boostrix	(
Annual Influenza – List vaccination for th	e current flu seas	on	//			
Tuberculosis (TB) Screening – Complete	ontion A or B to fi	ılfill th	nis requirement			
Option A: PPD (Mantoux) skin tests			·			
Required regardless of prior BCG vaccinati	ion.		PPD placed	PPD read		Induration
To complete this option:	-	PPD	1 / /	1	/	mm
2 step PPD (consisting of 2 PPDs placed 1-	3 weeks apart	000	· · · · · ·	,		
and read 48-72 hours after placement) wi	thin the past 6	PPD	Z //	/	/	mm
months of your enrollment date.	· · · · ·	Both	n tests must be < 10mm	•		
If PPD is positive (≥ 10mm), is the student free of TB syn If yes, list date of the positive PPD and induration Was the student treated? □Yes □No If yes, for how long was the student treated and win <u>If PPD is positive</u> : option B or a chest x-ray** must b 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. <u>Lab report must be attached.</u> <u>If your TB Blood test result is positive</u> , a chest x-ray** must be completed.			//, hpleted. hod test e:// e: □ QuantiFERON Gold b Report attached		Jegative □	Positive
**Chest x-ray result			st x-ray			
If you did NOT have a positive PPD or	•	Date://				
test, do NOT complete this option.		Normal Abnormal				
To complete this option a chest x-ray w	•	□ Re	port attached			
months must be normal , and report must be attached.						
Varicella (Chicken Pox) – Complete optio	n A or B to fulfill t	his red	quirement			
Option A: Varicella vaccine dosesVaccineFirst dose on or after your first birthday and a second dose at least 28 days apartVaricella dose 1			Date (mm/dd/yyyy)	Result		
			//			
			//			
Option B: Varicella serologic immunity To satisfy this option, you must submit a						



R	RUTGERS
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Last name		First name	·	[DOB (mm/dd/yyyy)		r
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 r			•					
Check all that apply	•							
 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 gradua								
You have one or me								or complement
inhibitor use, HIV		0	·	,	, 0	, ,	,	·
□ You are a traveler t	o/resident o	f areas with	endemic mer	ningitis				
If you checked any o	of the boxe	s above, y	ou must rece	eive at leas	t one dose of a	n approved Me	eningitis ACYW.	
Meningitis ACYW	Vaccine		Date (mm/d		Manufacturer		•	
The most recent			•					
dose must be on	Men ACYV	V dose 1	/	/	Menveo	🗆 Menactra	Menomune	🗆 MenQuadfi
or after your 16th								
birthday.	Men ACYV	V dose 2	/	/	🗆 Menveo	Menactra	🗆 Menomune	🗆 MenQuadfi
•								
Meningitis B requi		sessmen	L					
Check all that apply				aia aialda ad	II NI na animarita			
You have one or me inhibitor use UNV	ore of the fo	nowing con	ditions: aspier	hia, sickle ce	eii, N. meningitia	is lab work, comp	plement denciency	or complement
inhibitor use, HIV You are a traveler t 	o/rocidont o	faraacwitk	andomic mo	ningitic				
						ion Doonioo		
If you checked any o		s above, y						
Meningitis B	Vaccine		Date (mm/	dd/yyyy)	Manufacturer	•	[
	Men B dos	se 1	/	_/	🗆 Trumenba 🗆		Bexsero	
	Men B dos	se 2	//		🗆 Trumenba		🗆 Bexsero	
	Men B dos	se 3	/	/ 🗆 Trumenba				
Please tell us if you've received the following vaccine. It is highly recommended but not required.								
Vaccine		Date (mn	n/dd/yyyy)	Manufac	turer			
Human Papilloma V	ïrus	/	/	Gardas		sil 9 🗆 Cerva	rix 🗆 Unknow	n
•		/		🗆 Gardas	il 4 🗆 Gardas	sil 9 🗆 Cerva	rix 🗆 Unknow	n

Please tell us about additional vaccinations you may have received.

🗆 Gardasil 9

Cervarix

🗆 Unknown

Gardasil 4

/___

_/__

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	//	



Last name	First name	DOB (mm/dd/yyyy)	RUID or A number
Rabies	///		
	//		
	//		
Typhoid (most recent dose)	//	TyphIM Vivotif	
Yellow Fever	//		