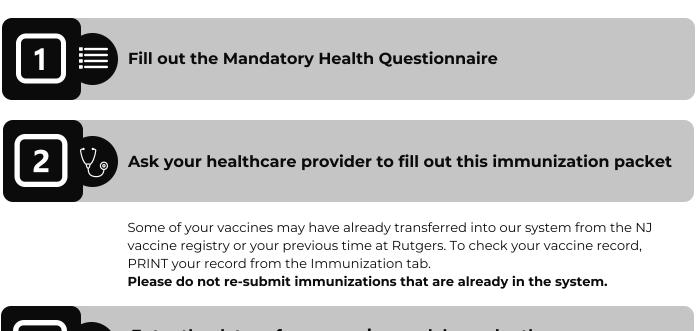


# **Immunization Packet - 4 steps**

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



Enter the dates of your vaccines or labs under the immunization tab



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.

<u>Required:</u> Measles Mumps Rubella Hepatitis B, including labs for immunity Adult Tdap Tuberculosis screening Varicella Annual flu

<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://patient-rbhs.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):	Date	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	//			
<b>Option B: MMR serological immunity</b>	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.					



varicella.

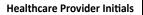
ATTACHMENT

LAB REPORTS ARE REQUIRED AND

MUST BE UPLOADED AS AN

Last name First	name		_ D	OB (mm/dd/yyyy) _		RUID (	or A number _	
Section B: Hep B vaccine doses		Vaccine		Date (mm/dd/yy	/vv)	Manufactu	rer	
If starting the series, at least one dos	e is	Hep B dose	e 1	/ /		Engerix	□ Twinrix	Heplisav
required prior to enrollment.		Hep B dose				🗆 Engerix	Twinrix	□ Heplisav
		Hep B dose				Engerix		
Adult Tdap (Tetanus, Diphtheria & A	cellular Pert					□ Adacel		,
		455157		//				<u> </u>
Annual Influenza – List vaccination for the current flu sea.			n	//				
Tuberculosis (TB) Screening – Com	olete option	A or B to fu	lfill th	is requirement				
Option A: PPD (Mantoux) skin tests				PPD placed		PPD read		Induration
Required regardless of prior BCG vac	cination.		000	-			,	
To complete this option: 2 step PPD (consisting of 2 PPDs plac	od 1_3 wook	rs anart	PPD			/	/	mm
and read 48-72 hours after placemer		-	PPD	2//		/	/	mm
months of your enrollment date.			Both tests must be < 10mm.					
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 wi <u>If PPD is positive</u> : option B or a chest x-ray** must B <b>Option B: FDA approved blood test</b> 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.		ted and with y** must be ction e.	h whi e com <b>Bloo</b> Date Type	ch medication?	Gold		egative 🗆	Positive
**Chest x-ray result			Chest x-ray					
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 <u>normal</u> , and <u>report must be attached.</u>		ne past 6	Date:/ Date:/ Normal Date: Report attached					
Varicella (Chicken Pox) – Complete	option A or	B to fulfill th	nis req	uirement				
Option A: Varicella vaccine doses	Vacci	ne	D	ate (mm/dd/yyyy)	)	Result		
First dose on or after your first birtho		ella dose 1		//	_			
and a second dose at least 28 days a	part Varic	ella dose 2		//				
Option B: Varicella serologic immun	ity							

To satisfy this option, you must submit a blood test demonstrating immunity to □ Immune □ Non-Immune Varicella titer Lab Report attached



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Last name		First name	<u> </u>	[	DOB (mm/dd/yyy	/y)	RUID or A number	
<b>Meningitis ACYW and Meningitis B</b> – Meningitis vaccines are required for students who meet the criteria listed below. Please complete the assessment to determine your requirement.								
•		-	-					
Meningitis ACYW r	equiremen	t assessm	ient					
Check all that apply	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	/ • • • •	с ···						
You are a traveler t				-				
If you checked any o		s above, y					eningitis ACYW.	
Meningitis ACYW	Vaccine		Date (mm/d	ld/yyyy)	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	irement as	sessmen	t					
Check all that apply								
□ You have one or m		llowing con	ditions: aspler	nia. sickle ce	ell. N. meningitid	is lab work. com	plement deficiency	or complement
inhibitor use, HIV				,			,	
You are a traveler t	o/resident o	f areas with	n endemic mei	ningitis				
If you checked any o					ingitis vaccinat	ion B series.		
Meningitis B	Vaccine		Date (mm/		Manufacturer			
0.11	Men B dos	se 1	/	_/	□ Trumenba		🗆 Bexsero	
	Men B dos	se 2	/	_/	🗆 Trumenba		🗆 Bexsero	
	Men B dos	se 3			🗆 Trumenba			
Please tell			ed the follo	wing vacc		ly recommend	led but not req	uired.
Vaccine		Date (mn	n/dd/yyyy)	Manufac	turer			
Human Papilloma V	irus	/			Gardasil 4 🗆 Gardasil 9 🗆 Cervarix 🗆 Unknown			
		/	/	🗆 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	//		





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Questions? Log in and send us a secure message.

# **Physical Form**

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

Last name	First name	DOB (mm/dd/yyyy)	
RUID or A number	Email	Cell phone	
School/Program		Grad year	

### Healthcare provider to complete

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 explai	in:	
General appearance					
Skin					
Head					
Eyes					
Neurological Exam					
Respiratory					
Psychiatric Exam					
			Data	Durationalise	

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