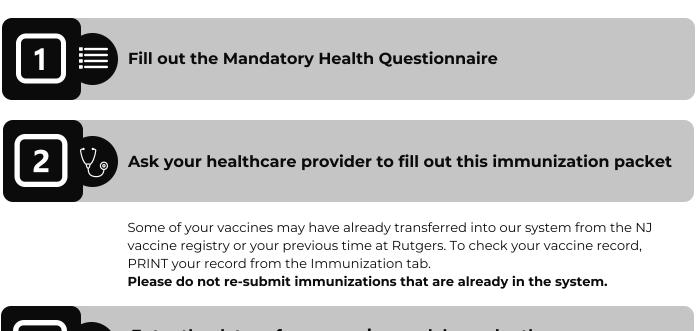


## **Immunization Packet - 4 steps**

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	//					
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.							



varicella.

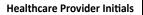
ATTACHMENT

LAB REPORTS ARE REQUIRED AND

MUST BE UPLOADED AS AN

Last name First r	name	DOB (mm/dd/yyyy) RU			RUID (	or A number _		
Section B: Hep B vaccine doses	Vaccine		<b>Date</b> (mm/dd/yyyy)		Manufacturer			
If starting the series, at least one dose	· · · · · · · · · · · · · · · · · · ·		Hep B dose 1		/	Engerix	□ Twinrix	Heplisav
required prior to enrollment.		Hep B dos			/	🗆 Engerix	🗆 Twinrix	□ Heplisav
		Hep B dose 3		/	/	Engerix		
Adult Tdap (Tetanus, Diphtheria & Ac	ellular Pert	•		/	/		Boostrix	,
Addie Todp (Tetantas, Dipititiena & Ad				/	./			<u> </u>
Annual Influenza – List vaccination f	or the curre	ent flu seasc	n	/	/			
Tuberculosis (TB) Screening – Comp	lete option	A or B to fu	lfill th	is requirement	t			
Option A: PPD (Mantoux) skin tests				PPD placed	d	PPD read		Induration
Required regardless of prior BCG vacc	ination.			-		/	,	
To complete this option: 2 step PPD (consisting of 2 PPDs place	nd 1-3 wool	(s anart	PPD		/	/	/	mm
and read 48-72 hours after placement			PPD	2/	/	/	/	mm
months of your enrollment date.		c past o	Both	n tests must be	< 10mm.			
<ul> <li>If yes, list date of the positive PPD and induration. Was the student treated? □Yes □No</li> <li>If yes, for how long was the student treated and wi</li> <li><u>If PPD is positive</u>: option B or a chest x-ray** must</li> <li><b>Option B: FDA approved blood test</b></li> <li>To complete this option, you must supply an FDA</li> <li>approved blood test showing absence of TB infection</li> <li>within the past 6 months of your enrollment date.</li> <li><u>Lab report must be attached.</u></li> <li><u>If your TB Blood test result is positive</u>, a chest x-ray**</li> </ul>			h whi e com <b>Bloo</b> Date Type	ch medication	? / ON Gold		legative 🗆	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>		he past 6	Date:/ Date:/ Normal Date: Report attached					
Varicella (Chicken Pox) – Complete c	ption A or	B to fulfill th	nis req	quirement				
Option A: Varicella vaccine doses	Vacc	ine	D	<b>ate</b> (mm/dd/y	ууу)	Result		
First dose on or after your first birthd	•	aricella dose 1		//				
and a second dose at least 28 days ap	art Varic	ella dose 2	_	//				
Option B: Varicella serologic immuni	ty							

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	me D		DOB (mm/dd/yyyy)		RUID or A number	
Meningitis ACYW and Meningitis B – Meningitis vaccines are required for students who meet the criteria listed below. Please								
complete the assessm		-	-					
Meningitis ACYW r	equiremen	it assessm	ient					
Check all that apply	below.							
You will be under 19 years old at the start of your first semester								
This will be your fir								
(A transfer or gradua			•			• • •	• ·	
□ You have one or m	ore of the fo	llowing con	ditions: aspler	nia, sickle ce	ell, N. meningitid	is lab work, comp	plement 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	•		1
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	//				MenQuadfi	
Meningitis B requi	irement as	sessmen	t					
Check all that apply								
<ul> <li>You have one or m</li> </ul>		llowing con	ditions: aspler	nia. sickle ce	ell. N. meningitid	is lab work. com	plement deficiency	or complement
inhibitor use, HIV				.,	, - 0	,		
□ 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			
Ū	Men B dos	se 1	/	_/	🗆 Trumenba		Bexsero	
	Men B dos	se 2	//					
	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	irus	/	/	🗆 Gardas	il 4 🛛 🗆 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	//		