Immunization Packet - 4 steps

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



Fill out the Mandatory Health Questionnaire



Ask your healthcare provider to fill out this immunization packet

Some of your vaccines may have already transferred into our system from the NJ vaccine registry or your previous time at Rutgers. To check your vaccine record, PRINT your record from the Immunization tab.

Please do not re-submit immunizations that are already in the system.



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 (Category 2) immunization requirements apply to students who will see patients or clients during the course of their program but have no risk of exposure to blood or infectious body fluids. Not sure of your category? Reach out to your program.

Required: Measles Mumps Rubella **Hepatitis B Adult Tdap Tuberculosis screening** Varicella Annual flu

May be required (see immunization form for details): **Meningitis ACYW** Meningitis B



Student to complete

Last name RUID or A number School/Program	_ First name _ Email	Cell	B <i>(mm/dd/yyyy)</i> phone d year	
	Healthcare provider to	complete		
Healthcare provider name (print):	Date		Practice stamp	
Healthcare provider name (sign):	I			
NPI:				
Measles, Mumps, Rubella (MMR) – Comp	lete option A, B, or C to fulfill t	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	<u> </u>		
second dose at least 28 days after.	MMR dose 2	/	-	
Option B: MMR serological immunity		/ /		
To satisfy this option, blood tests must	Measles (Rubeola) titer		☐ Immune ☐ Non-Immune	
demonstrate immunity to measles,				
mumps, and rubella. LAB REPORTS ARE REQUIRED AND MUST	Mumps titer		☐ Immune ☐ Non-Immune	
BE UPLOADED TO THE PORTAL	Rubella titer		□ Immune □ Non-Immune	
Option C: Measles, Mumps and Rubella	Measles dose 1	/ /	- minute - Non-initialie	
immunizations if given separately.	Measles dose 2			
Doses may be entered individually in this			-	
section.	Mumps dose 1			
DO NOT RE-ENTER DOSES IF LISTED ABOVE	Mumps dose 2		_	
DO NOT RE-ENTER DOSES IF LISTED ABOVE	Rubella dose 1			
Hepatitis B				
Hep B antibody test	Test	Date (mm/dd/yyyy)	Lab Results	
To satisfy the requirement, you must	Quantitative Hep B		☐ Immune (≥10 mIU/mL)	
provide a QUANTITATIVE Hep B surface	surface antibody		☐ Non-immune (If you are	
antibody test showing immunity to			non-immune you must provide	
Hepatitis B.			a Hep B surface antigen and	
LAB REPORTS ARE REQUIRED AND MUST			restart the series) □ Non-responder (after 2	
BE UPLOADED TO THE PORTAL			complete series)	
Hep B surface antigen	Hep B surface antigen		complete series/	
We recommend submitting a Hep B				
surface antigen in case the quantitative			☐ Negative ☐ Positive	
Hep B surface antibody does not				
demonstrate immunity.				

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Healthcare	Provider	Initials



Last name First 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)	Manufactur	rer		
Tiep b vaccine doses	Hep B dose 1	/ /	□ Engerix	□ Twinrix	□ Heplisav	
	Hep B dose 2	/ /	☐ Engerix	□ Twinrix	□ Heplisav	
	Hep B dose 3	/ /	☐ Engerix	□ Twinrix	-r	
Repeat Hepatitis B series	Vaccine	Date (mm (dd (mm))	Manufactur		•	
Only if not immune after primary series,		Date (mm/dd/yyyy)				
receive booster dose OR complete series	Hep B dose 4	/	□ Engerix	□ Twinrix□ Twinrix	☐ Heplisav☐ Heplisav	
before rechecking for immunity.**	Hep B dose 5		□ Engerix	□ Twinnix	□ Heplisav	
	Hep B dose 6		□ Engerix	□ IWIIIIX		
**Student MUST demonstrate immunity to	fulfill the	Quantitative Hep B	surface antib	oody		
requirement. Immunity can be checked 4-6 weeks after a vaccine dose. LAB REPORT(S) MUST BE UPLOADED TO THE PORTAL			□ Immune □ Non-imm	(≥10 mIU/mL) nune		
Adult Tdap (Tetanus, Diphtheria & Acellular	Pertussis)	/ /	□ Adacel	□ Boostrix		
radic rade (returns, Diprierera & recinata	1 61 6433137		- / ladeel			
Annual Influenza – List vaccination for the o	current flu season	/				
Tuberculosis (TB) Screening – Complete op	 ption Δ or B to fulfill	this requirement				
Option A: PPD (Mantoux) skin tests	tion A or B to juijiii	tins requirement				
Required regardless of prior BCG vaccination	PPD place	ed	PPD read	Induration		
To complete this option:		PPD 1//		//_	mm	
2 step PPD (consisting of 2 PPDs placed 1-3 v	•	PPD 2 / /			mm	
read 48-72 hours after placement) within the past 6 months			. 10	<i></i>		
of your enrollment date.	Both tests must be					
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 Blood test						
To complete this option, you must provide a	Date:/ Result: □ Negative □ Positive					
blood test showing absence of TB infection within the past 6		T = Overtiferen Cald				
months of your enrollment date. LAB REPORT MUST BE UPLOADED TO THE PORTAL		Type: □ QuantiFeron Gold □ T-Spot				
	□ I-Spot					
If your TB Blood test result is positive, a chest x-ray**		☐ Lab report attache	ed			
must be completed.		·				
**Chest x-ray result	ain tha nact C	Chest x-ray				
To complete this option a chest x-ray with	•	Date://_				
months must be normal and report must be uploaded to the portal.		□ Normal □ Abnormal □ Report attached				
<u>ine portui.</u>						

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Last name	First name	DOB		′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 afte	r your first birthday a	nd Varicella dose	1	/		
a second dose at lea	st 28 days apart	Varicella dose	2			
Option B: Varicella	serologic immunity					
-	n, you must provide a					
blood test demonst	rating immunity to	Varicella titer		1 1	□ Immune □ Non-Immune	
varicella.		varicena titei			□ Lab report a	attached
	REQUIRED AND MUST	BE				
UPLOADED AS AN A	TTACHMENT					
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	-					
·-	19 years old at the star	t of your first semester				
□ This will be your f	irst year in any college a	and you will be living in	campus hou	sing, 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 r complement inhil	nore of the following co	nditions: asplenia, sick	le cell, N. me	ningitidis lab work, con	nplement deficier	ncy or
-		th endemic meningitis				
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.						
If you checked any	or the boxes above, y	ou must receive at it	east one dos	se of an approved M	eningitis ACYW.	
Meningitis ACYW	Vaccine	Date (mm/dd/yyyy)	Manufact	• •	eningitis ACYW	•
	Vaccine		Manufact	urer		
Meningitis ACYW			1	urer	eningitis ACYW	_
Meningitis ACYW The most recent dose must be on or after your 16th	Vaccine Men ACYW dose 1		Manufact □ Menveo	urer D	□ Menomune	□ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday.	Men ACYW dose 1 Men ACYW dose 2		Manufact	urer D		
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require	Men ACYW dose 1 Men ACYW dose 2 ement assessment		Manufact □ Menveo	urer D	□ Menomune	□ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply	Men ACYW dose 1 Men ACYW dose 2 ement assessment below:	Date (mm/dd/yyyy)	Manufact □ Menveo □ Menveo	urer	□ Menomune □ Menomune	□ MenQuadfi □ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply You have one or	Men ACYW dose 1 Men ACYW dose 2 ment assessment below: more of the following	Date (mm/dd/yyyy)	Manufact □ Menveo □ Menveo	urer	□ Menomune □ Menomune	□ MenQuadfi □ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply Vou have one or complement interests.	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV	Date (mm/dd/yyyy)	Manufact ☐ Menveo ☐ Menveo a, sickle cell	urer	□ Menomune □ Menomune	□ MenQuadfi □ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply Vou have one or complement inf	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV er to/resident of areas	Date (mm/dd/yyyy)	Manufact ☐ Menveo ☐ Menveo a, sickle cell,	urer	□ Menomune □ Menomune	□ MenQuadfi □ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply You have one or complement inf You are a travele If you checked any	Men ACYW dose 1 Men ACYW dose 2 ment assessment below: more of the followin hibitor use, HIV er to/resident of areas of the boxes above, y	Date (mm/dd/yyyy)	Manufact ☐ Menveo ☐ Menveo a, sickle cell, ngitis eningitis B v	urer	□ Menomune □ Menomune	□ MenQuadfi □ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply Vou have one or complement inf	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV er to/resident of areas of the boxes above, y Vaccine	Date (mm/dd/yyyy)	Manufact ☐ Menveo ☐ Menveo a, sickle cell,	urer D □ Menactra □	□ Menomune □ Menomune	□ MenQuadfi □ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply You have one or complement inf You are a travele If you checked any	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV er to/resident of areas of the boxes above, y Vaccine Men B dose 1	Date (mm/dd/yyyy)	Manufact Menveo Menveo A, sickle cell, ngitis eningitis B v Manufact Trumen	waccination series. urer Menactra Menactra vaccination series. urer ba Bexsero	□ Menomune □ Menomune	□ MenQuadfi □ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply You have one or complement inf You are a travele If you checked any	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV er to/resident of areas of the boxes above, y Vaccine Men B dose 1 Men B dose 2	Date (mm/dd/yyyy)	Manufact Menveo Menveo Menveo A, sickle cell, ngitis eningitis B v Manufact Trumen	waccination series. waccination series. urer ba	□ Menomune □ Menomune	□ MenQuadfi □ MenQuadfi
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply You have one or complement inh You are a traveled If you checked any of Meningitis B	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV er to/resident of areas of the boxes above, y Vaccine Men B dose 1 Men B dose 2 Men B dose 3	pate (mm/dd/yyyy)	Manufact Menveo Menveo A, sickle cell, ngitis eningitis B v Manufact Trumen Trumen	waccination series. waccination series. urer ba Bexsero ba Bexsero ba	□ Menomune □ Menomune work, compleme	□ MenQuadfi □ MenQuadfi ent deficiency or
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply You have one or complement inh You are a traveled If you checked any of Meningitis B	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV er to/resident of areas of the boxes above, y Vaccine Men B dose 1 Men B dose 2 Men B dose 3 if you have receive	pate (mm/dd/yyyy)	Manufact Menveo Menveo A, sickle cell, ngitis eningitis B v Manufact Trumen Trumen	waccination series. waccination series. urer ba Bexsero ba Bexsero ba	□ Menomune □ Menomune work, compleme	□ MenQuadfi □ MenQuadfi ent deficiency or
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply You have one or complement inh You are a travele If you checked any Meningitis B	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV er to/resident of areas of the boxes above, y Vaccine Men B dose 1 Men B dose 2 Men B dose 3	pate (mm/dd/yyyy)	Manufact Menveo Menveo Menveo A, sickle cell, ngitis eningitis B v Manufact Trumen Trumen Trumen	waccination series. waccination series. urer ba Bexsero ba Bexsero ba	□ Menomune □ Menomune work, compleme	□ MenQuadfi □ MenQuadfi ent deficiency or uired.
Meningitis ACYW The most recent dose must be on or after your 16th birthday. Meningitis B require Check all that apply You have one or complement inh You are a traveled If you checked any of Meningitis B	Men ACYW dose 1 Men ACYW dose 2 ement assessment below: more of the following hibitor use, HIV er to/resident of areas of the boxes above, y Vaccine Men B dose 1 Men B dose 2 Men B dose 3 if you have receive	pate (mm/dd/yyyy)	Manufact Menveo Menveo A, sickle cell, ngitis eningitis B v Manufact Trumen Trumen	waccination series. waccination series. urer ba Bexsero ba Bexsero ba	□ Menomune □ Menomune work, compleme	□ MenQuadfi □ MenQuadfi ent deficiency or uired.

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□ Gardasil 9

□ Cervarix

□ Unknown

☐ Gardasil 4





Last name	First name	DOB (<i>mm/dd/yyyy</i>) 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				

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