RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

**This form is for clinical students**

# Immunization Packet - 4 steps

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

**1** **Fill out the Mandatory Health Questionnaire**

**2** **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.**

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

**4** **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:**
- COVID-19: primary series or bivalent dose
- Measles Mumps Rubella
- Hepatitis B
- Adult Tdap
- Tuberculosis screening
- Varicella
- Annual flu

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

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## Student to complete *(please print or type)*

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

## Healthcare provider to complete *(please print or type)*

**Measles, Mumps, Rubella (MMR)** – *Complete option A, B, or C to fulfill this requirement*

| | | | |
|---|---|---|---|
| **Option A: MMR vaccine doses**<br>First dose on or after first birthday and a second dose at least 28 days after. | **Vaccine/Titer** | **Date** *(mm/dd/yyyy)* | **Result** |
| | MMR dose 1 | _____/_____/_____ | [redacted] |
| | MMR dose 2 | _____/_____/_____ | |
| **Option B: MMR serological immunity**<br>To satisfy this option, blood tests must demonstrate immunity to measles, mumps, and rubella.<br>**LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT** | Measles *(Rubeola)* titer | _____/_____/_____ | □ Immune □ Non-Immune |
| | Mumps titer | _____/_____/_____ | □ Immune □ Non-Immune |
| | Rubella titer | _____/_____/_____ | □ Immune □ Non-Immune |
| **Option C: Measles, Mumps and Rubella immunizations if given separately.**<br>Doses may be entered individually in this section.<br>*DO NOT RE-ENTER DOSES IF LISTED ABOVE* | Measles dose 1 | _____/_____/_____ | [redacted] |
| | Measles dose 2 | _____/_____/_____ | |
| | Mumps dose 1 | _____/_____/_____ | |
| | Mumps dose 2 | _____/_____/_____ | |
| | Rubella dose 1 | _____/_____/_____ | |

**Hepatitis B** – *Complete option A or B to fulfill this requirement*

| | | | |
|---|---|---|---|
| **Option A: Hep B vaccine doses**<br>If starting the series, at least one dose is required prior to enrollment. | **Vaccine** | **Date** *(mm/dd/yyyy)* | **Manufacturer** |
| | Hep B dose 1 | _____/_____/_____ | □ Engerix □ Twinrix □ Heplisav |
| | Hep B dose 2 | _____/_____/_____ | □ Engerix □ Twinrix □ Heplisav |
| | Hep B dose 3 | _____/_____/_____ | □ Engerix □ Twinrix |
| **Option B: Hep B antibody test**<br>To satisfy the option, you must supply a QUANTITATIVE Hep B Surface Antibody test showing immunity to Hepatitis B.<br>***LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT*** | **Test** | **Date** *(mm/dd/yyyy)* | **Lab Results** |
| | Quantitative Hep B surface antibody | _____/_____/_____ | □ Immune (≥10 mIU/mL)<br>□ Non-immune<br>□ Lab report attached |

**COVID-19** – *A primary series or a bivalent dose is required*

| | | | |
|---|---|---|---|
| All doses must be FDA or WHO-approved. | **Vaccine** | **Date** (mm/dd/yyyy) | **Manufacturer** |
| | Dose 1 | _____/_____/_____ | |
| | Dose 2 | _____/_____/_____ | |
| | Most recent booster | _____/_____/_____ | |

| | | |
|---|---|---|
| **Adult Tdap** *(Tetanus, Diphtheria & Acellular Pertussis)* | _____/_____/_____ | □ Adacel □ Boostrix |

| | |
|---|---|
| **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**<br>*Required regardless of prior BCG vaccination.*<br>To complete this option:<br>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. | **PPD placed** **PPD read** **Induration**<br>**PPD 1** _____/_____/_____ _____/_____/_____ _____ mm<br>**PPD 2** _____/_____/_____ _____/_____/_____ _____ mm<br>***Both tests must be < 10mm.*** |
| **If PPD is positive (≥ 10mm), is the student free of TB symptoms?** □Yes □No<br>If yes, list date of the positive PPD and induration. _____/_____/_____, _____ mm<br>Was the student treated? □Yes □No<br>If yes, for how long was the student treated and with which medication? _____<br>*If PPD is positive*: option B or a chest x-ray** must be completed. | |
| **Option B: FDA approved blood test**<br>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.<br>**Lab report must be attached.**<br>*If your TB Blood test result is positive*, a chest x-ray** must be completed. | **Blood test**<br>Date: _____/_____/_____ Result: □ Negative □ Positive<br>Type: □ QuantiFERON Gold □ T-Spot<br>□ Lab report attached |
| ****Chest x-ray result**<br>**If you did NOT have a positive PPD or positive blood test, do NOT complete this option.**<br>*To complete this option a chest x-ray within the past 6 months must be **normal**, and **report must be attached.*** | **Chest x-ray**<br>Date: _____/_____/_____<br>□ Normal □ Abnormal _____<br>□ Report attached |

| **Varicella (Chicken Pox)** – *Complete option A or B to fulfill this requirement* | | | |
|---|---|---|---|
| **Option A: Varicella vaccine doses**<br>First dose on or after your first birthday and a second dose at least 28 days apart | **Vaccine/Titer**<br>Varicella dose 1<br>Varicella dose 2 | **Date** (mm/dd/yyyy)<br>_____/_____/_____<br>_____/_____/_____ | **Result** |
| **Option B: Varicella serologic immunity**<br>To satisfy this option, you must submit a blood test demonstrating immunity to varicella.<br>**LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT** | **Varicella Titer** | _____/_____/_____ | □ Immune □ Non-Immune<br>□ Lab Report attached |

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**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 vaccination B 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 ***(either a 2 or 3 dose series)*** | |

**Please tell us if you've received the following vaccine. It is highly recommended but not required.**

| **Vaccine** | **Date** *(mm/dd/yyyy)* | **Manufacturer** | | | |
|---|---|---|---|---|---|
| **Human Papilloma Virus** | _____/_____/_____ | □ Gardasil 4 | □ Gardasil 9 | □ Cervarix | □ Unknown |
| | _____/_____/_____ | □ Gardasil 4 | □ Gardasil 9 | □ Cervarix | □ Unknown |
| | _____/_____/_____ | □ Gardasil 4 | □ Gardasil 9 | □ Cervarix | □ Unknown |

**Please tell us about additional vaccinations you may have received.**

| **Vaccine** | **Date** *(mm/dd/yyyy)* | **Other Details** |
|---|---|---|
| **Hepatitis A** | _____/_____/_____<br>_____/_____/_____ | [redacted] |
| **Japanese Encephalitis** | _____/_____/_____<br>_____/_____/_____ | |
| **Pneumococcal** | _____/_____/_____ | □ PCV13 □ PPSV23 |
| | _____/_____/_____ | □ PCV13 □ PPSV23 |
| | _____/_____/_____ | □ PCV13 □ PPSV23 |
| | _____/_____/_____ | □ PCV13 □ PPSV23 |

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| | | |
|---|---|---|
| **Polio Booster** | _____/_____/_____ | |
| **Rabies** | _____/_____/_____<br>_____/_____/_____<br>_____/_____/_____ | |
| **Typhoid *(most recent dose)*** | _____/_____/_____ | □ TyphIM □ Vivotif |
| **Yellow Fever** | _____/_____/_____ | |

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