





# Immunization Packet - 4 steps


All forms and uploads must be completed at <https://patient-rbhs.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:**

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

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

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

Last name \_\_\_\_\_ First name \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_ RUID or A number \_\_\_\_\_

<b>Section B: Hep B vaccine doses</b> If starting the series, at least one dose is required prior to enrollment.	<b>Vaccine</b>	<b>Date (mm/dd/yyyy)</b>	<b>Manufacturer</b>
	Hep B dose 1	____/____/____	<input type="checkbox"/> Enderix <input type="checkbox"/> Twinrix <input type="checkbox"/> Heplisav
	Hep B dose 2	____/____/____	<input type="checkbox"/> Enderix <input type="checkbox"/> Twinrix <input type="checkbox"/> Heplisav
	Hep B dose 3	____/____/____	<input type="checkbox"/> Enderix <input type="checkbox"/> Twinrix
<b>Adult Tdap (Tetanus, Diphtheria &amp; Acellular Pertussis)</b>		____/____/____	<input type="checkbox"/> Adacel <input type="checkbox"/> Boostrix

<b>Annual Influenza – List vaccination for the current flu season</b>	____/____/____
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**Tuberculosis (TB) Screening – Complete option A or B to fulfill this requirement**

<b>Option A: PPD (Mantoux) skin tests</b> <i>Required regardless of prior BCG vaccination.</i> To complete this option: 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.	<b>PPD placed</b>	<b>PPD read</b>	<b>Induration</b>	
	PPD 1	____/____/____	____/____/____	____ mm
	PPD 2	____/____/____	____/____/____	____ mm
	<b>Both tests must be &lt; 10mm.</b>			

**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.*

<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. <b>Lab report must be attached.</b> <i>If your TB Blood test result is positive, a chest x-ray** must be completed.</i>	<b>Blood test</b>
	Date: ____/____/____   Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Type: <input type="checkbox"/> QuantiFERON Gold <input type="checkbox"/> T-Spot  <input type="checkbox"/> Lab Report attached

<b>**Chest x-ray result</b> <b>If you did NOT have a positive PPD or positive blood test, do NOT complete this option.</b> <i>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>.</i>	<b>Chest x-ray</b> Date: ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____ <input type="checkbox"/> Report attached
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**Varicella (Chicken Pox) – Complete option A or B to fulfill this requirement**

<b>Option A: Varicella vaccine doses</b> First dose on or after your first birthday and a second dose at least 28 days apart	<b>Vaccine</b>	<b>Date (mm/dd/yyyy)</b>	<b>Result</b>
	Varicella dose 1	____/____/____	
	Varicella dose 2	____/____/____	

<b>Option B: Varicella serologic immunity</b> To satisfy this option, you must submit a blood test demonstrating immunity to varicella. <b>LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT</b>	<b>Varicella titer</b>	____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Lab Report attached
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Last name \_\_\_\_\_ First name \_\_\_\_\_ 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 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 The most recent dose must be on or after your 16th birthday.	Vaccine	Date (mm/dd/yyyy)	Manufacturer			
	Men ACYW dose 1	___/___/___	<input type="checkbox"/> Menveo	<input type="checkbox"/> Menactra	<input type="checkbox"/> Menomune	<input type="checkbox"/> MenQuadfi
Men ACYW dose 2	___/___/___	<input type="checkbox"/> Menveo	<input type="checkbox"/> Menactra	<input type="checkbox"/> Menomune	<input type="checkbox"/> 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	___/___/___	<input type="checkbox"/> Trumenba	<input type="checkbox"/> Bexsero
	Men B dose 2	___/___/___	<input type="checkbox"/> Trumenba	<input type="checkbox"/> Bexsero
	Men B dose 3	___/___/___	<input type="checkbox"/> Trumenba	

**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	___/___/___	<input type="checkbox"/> Gardasil 4	<input type="checkbox"/> Gardasil 9	<input type="checkbox"/> Cervarix	<input type="checkbox"/> Unknown
	___/___/___	<input type="checkbox"/> Gardasil 4	<input type="checkbox"/> Gardasil 9	<input type="checkbox"/> Cervarix	<input type="checkbox"/> Unknown
	___/___/___	<input type="checkbox"/> Gardasil 4	<input type="checkbox"/> Gardasil 9	<input type="checkbox"/> Cervarix	<input type="checkbox"/> Unknown

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

Vaccine	Date (mm/dd/yyyy)	
COVID-19 (most recent dose)	___/___/___	<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Other _____
Hepatitis A	___/___/___	___/___/___
Japanese Encephalitis	___/___/___	___/___/___
Pneumococcal	___/___/___	<input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23
	___/___/___	<input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23
	___/___/___	<input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23
	___/___/___	<input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23
Polio Booster	___/___/___	

Healthcare Provider Initials	
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Last name \_\_\_\_\_ First name \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_ RUID or A number \_\_\_\_\_

<b>Rabies</b>	____/____/____ ____/____/____ ____/____/____	
<b>Typhoid</b> <i>(most recent dose)</i>	____/____/____	<input type="checkbox"/> TyphIM <input type="checkbox"/> Vivotif
<b>Yellow Fever</b>	____/____/____	