RUTGERS

This form is for non-clinical students

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)**

Non-clinical student immunization requirements

Required:
Measles Mumps Rubella
Hepatitis B

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

Non-clinical students, 31 and over, are exempt from MMR & Hep B requirements.

Questions? Contact the Student Health line at RBHS-Newark at: 973-972-7687

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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 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	_____/_____/_____	
	MMR dose 2	_____/_____/_____	
Option B: MMR serological immunity To satisfy this option, blood tests must demonstrate immunity to measles, mumps, and rubella. **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. Doses may be entered individually in this section. *DO NOT RE-ENTER DOSES IF LISTED ABOVE*	Measles dose 1	_____/_____/_____	
	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 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 To satisfy the option, you must supply a QUANTITATIVE Hep B Surface Antibody test showing immunity to Hepatitis B. ***LAB REPORTS ARE REQUIRED AND MUST BE UPLOADED AS AN ATTACHMENT***	**Antibody Test**	**Date** *(mm/dd/yyyy)*	**Lab Results**
	Quantitative Hepatitis B Surface Antibody	_____/_____/_____	□ Immune (≥10 mIU/mL) □ Non-immune □ Lab Report Attached

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Healthcare Provider Initials	

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	**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	

Tuberculosis – *TB screening is required for students who meet the criteria below. Please complete the assessment to determine your requirement.*

Check all that apply below.

- □ Had close contact with persons known or suspected to have active TB disease?
- □ Spent more than one month OR was born in:

  Afghanistan, Algeria Angola, Anguilla, Argentina, Armenia, Azerbaijan, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Burkina Faso, Burundi, Côte d'Ivoire, Cabo Verde, Cambodia, Cameroon, Central African, Republic, Chad, China, Colombia, Comoros, Congo, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Fiji, Gabon, Gambia, Georgia, Ghana, Greenland, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho, Liberia, Libya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mexico, Micronesia (Federated States of), Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue, Northern Mariana, Islands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Tajikistan, Thailand, Timor-Leste, Togo, Tokelau, Tunisia, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe
- □ Lived in or been employed by a correctional facility, long-term care facility, or homeless shelter?
- □ Volunteered or worked with clients/patients at increased risk for active TB disease?

If you checked any of the boxes above, you must submit TB test results within the past 6 months of your enrollment date.

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Healthcare Provider Initials	

Last name _____ First name _____ DOB *(mm/dd/yyyy)* _____ RUID or A number _____

Complete option A or B to fulfill this requirement.	
Option A: PPD (Mantoux) skin test To satisfy this option, a PPD *(must be read 48-72 hours after placement)* within the past 6 months of your enrollment date. The test must be < 10mm. *If your PPD is positive,* option B or a chest x-ray must be completed.	**Results** PPD Placed: ____/_____/____ PPD read: ____/_____/_____ Induration _____ mm Result: □ Negative □ Positive
Option B: FDA approved blood test 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. **Lab report must be attached.** *If your TB blood test result is positive,* a chest x-ray must be completed.	**Blood test** Date: _____/_____/_____ Result: □ Neg □ Pos Type: □ QuantiFERON Gold □ T-Spot □ Lab Report Attached
****Chest x-ray result** 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 of your enrollment date, must be **normal**, and **report must be attached.***	**Chest x-ray** Date: _____/_____/_____ □ Normal □ Abnormal _____ □ Report Attached

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)*	
Adult Tdap	_____/_____/_____	□ Tdap □ Td
Varicella *(Chicken Pox)*	_____/_____/_____ _____/_____/_____	Varicella Serologic Immunity *(list date and attach lab report)* Date: _____/_____/_____ □ Immune □ Non-Immune
Annual flu *(for current flu season)*	_____/_____/_____	
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	_____/_____/_____	