

Dear Entering Student,

It is my pleasure to welcome you to Rutgers Biomedical and Health Sciences.

The following pages list our health and immunization requirements. Our policy protects you, our patients, and Rutgers staff and is based on CDC recommendations and NJ state law. Completing the requirements can take time, so keep this in mind as you schedule an appointment with your provider to complete the Immunization Record.

Please make sure your health care provider completes, signs and dates the Immunization Record and attaches all relevant labs. Review the checklist with your healthcare provider so that the appropriate tests are performed. Your provider may not be familiar with some of these requirements, but they are **REQUIRED**. The checklist may help to avoid the wrong tests being ordered at an increased cost to you, as any cost incurred related to the above requirements is your responsibility.

Once the Immunization Record is complete, log into the Student Health Portal at <https://patient-rbhs.medicatconnect.com/> and

1. Combine the Immunization Record, lab reports, and imaging into one document and upload it under the Upload tab
2. Complete the Mandatory Health Form under the Forms tab

In order to fulfill the tuberculosis screening, either a 2 step PPD (consisting of 2 PPDs placed 1-3 weeks apart and read 48-72 hours after placement) or an FDA approved blood test for tuberculosis may be submitted.

The RBHS “Student Immunization & Health Requirements” Policy may be accessed [here](#).

If you have any questions, cannot access the portal, or need a recommendation for a local health care provider, please contact Student Health Services at: 973-972-8219. Be sure to keep a copy of your paperwork for your own records.

Sincerely,



Noa'a Shimoni MD MPH
Director

Use your Rutgers login to upload this completed and signed form into
<http://patient-rbhs.medicalconnect.com>
 Questions? Send us a secure message through the portal

PART I: To be completed by the student. Please print or type.

Last name	First name	MI	RUID or A number	School/grad year/program
DOB (month day year)		Cell phone		Email

PART II: To be completed and signed by health care provider.

	Date (mo day yr)	Results if applicable
MMR (Measles/Rubeola, Mumps, Rubella) vaccine <i>or</i> serologic immunity (attach lab report)	___/___/___ Dose 1 ___/___/___ Dose 2 ___/___/___	Measles <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune Mumps <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune Rubella <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune
Meningitis ACYW (required for ALL students under 19, first year college students in housing, those with risk factors ^{1,2} , and specific travelers ³) with at least 1 dose since age 16 Meningitis B (required for students with risk factors ¹) ¹ asplenia, sickle cell, N meningitidis lab work, complement deficiency or complement inhibitor use ² HIV ³ travelers to/residents of areas with endemic meningitis	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	<input type="checkbox"/> Menveo <input type="checkbox"/> Menactra <input type="checkbox"/> Menomune <input type="checkbox"/> Menveo <input type="checkbox"/> Menactra <input type="checkbox"/> Menomune <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexero <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexero <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexero
QUANTITATIVE Hepatitis B Surface Antibody Titer qualitative will not be accepted per CDC guidelines <i>We recommend submitting a Hepatitis B Surface Antigen as well in case immunity is not demonstrated (attach lab reports). If starting the series, at least 1 dose is required prior to enrollment.</i> <input type="checkbox"/> Enderix <input type="checkbox"/> Heplisav <input type="checkbox"/> Twinrix <input type="checkbox"/> Enderix <input type="checkbox"/> Heplisav <input type="checkbox"/> Twinrix <input type="checkbox"/> Enderix <input type="checkbox"/> Heplisav <input type="checkbox"/> Twinrix	___/___/___ Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3	Hep B Surface Antibody ___/___/___ <input type="checkbox"/> Immune (≥10 mIU/mL) <input type="checkbox"/> Non-immune Hep B Surface Antigen ___/___/___ <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Tuberculosis <u>Two</u> PPDs or an FDA approved blood test are required regardless of prior BCG within the past 6 months of matriculation <i>or</i> FDA approved blood test (attach lab report)	PPD placed PPD #1 ___/___/___ PPD #2 ___/___/___ ___/___/___	PPD read induration ___/___/___ ___ mm ___/___/___ ___ mm <input type="checkbox"/> Negative <input type="checkbox"/> Positive
If PPD positive (≥10 mm), is the patient free of TB symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No For positive PPD: a normal chest x-ray or negative FDA approved blood test is required within the past 6 months (attach report). For positive TB blood test: a chest x-ray is required within the past 6 months (attach report)	Blood test ___/___/___ Chest x-ray ___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Normal <input type="checkbox"/> Findings:
Adult Tdap (Tetanus, Diphtheria & Acellular Pertusis) (Adacel or Boostrix)	___/___/___	
Varicella (chicken pox) vaccine <i>or</i> Varicella serologic immunity (attach lab report)	___/___/___ Dose1 ___/___/___ Dose 2	Antibody ___/___/___ <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune
Annual flu (list vaccination for the current flu season)	___/___/___	
COVID-19 vaccine <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> J&J <input type="checkbox"/> other: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> J&J <input type="checkbox"/> other: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> J&J <input type="checkbox"/> other:	___/___/___ ___/___/___ ___/___/___	
Healthcare provider name	Signature	Date

