Student Health Services
Rutgers Health Sciences Campus at Newark
90 Bergen Street, Suite 1750
Newark, NJ 07103
p 973-972-7687
f 973-972-0018

Dear Visiting or Continuing Education 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 Packet.

Please make sure to have your health care provider complete, sign and date the Immunization Packet and **attach all supporting immunization records.** 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. A physical exam within the past year is required by many clinical rotation sites.

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. If you have received annual PPDs or tuberculosis blood tests, you may submit those instead.

The RBHS "Student Immunization & Health Requirements" Policy may be accessed at https://policies.rutgers.edu/file/3129/download?token=RgpyIjFa

If you have any questions, require additional information, or need a recommendation for a local health care provider, please contact Student Health Services at: 973-972-7687. The forms and additional immunization records must be submitted electronically via the link below. Please allow two (2) weeks for the Immunization Team to review your documents and notify you via secure email of their status. Be sure to keep a copy of your paperwork for your own records.

Submission Link: **https://redcap.link/2y54qcyh**

Sincerely,

Noa'a Shimoni MD MPH
Medical Director

RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

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Upload this completed and signed form into https://redcap.link/2y54qcyh

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 *or* serologic immunity (attach lab report)	__/__/___ *Dose 1* __/__/___ *Dose 2* __/__/___	Measles ☐Immune ☐Non-immune Mumps ☐Immune ☐Non-immune Rubella ☐Immune ☐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**	__/__/___ __/__/___	☐Menveo ☐Menactra ☐Menomune ☐Menveo ☐Menactra ☐Menomune
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*	__/__/___ __/__/___ __/__/___	☐Trumenba ☐Bexero ☐Trumenba ☐Bexero ☐Trumenba ☐Bexero
QUANTITATIVE Hepatitis B Surface Antibody Titer qualitative will not be accepted per CDC guidelines *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.* ☐Engerix ☐Heplisav ☐Twinrix ☐Engerix ☐Heplisav ☐Twinrix ☐Engerix ☐Heplisav ☐Twinrix	 __/__/___ *Dose 1* __/__/___ *Dose 2* __/__/___ *Dose 3*	**Hep B Surface Antibody** __/__/___ ☐ Immune (≥10 mIU/mL) ☐ Non-immune **Hep B Surface Antigen** __/__/___ ☐ Negative ☐ Positive
Tuberculosis **Two** PPDs or an FDA approved blood test are required regardless of prior BCG within the past 6 months of matriculation *or* FDA approved blood test (attach lab report)	PPD placed PPD #1 __/__/___ PPD #2 __/__/___ __/__/___	PPD read induration __/__/___ ___ mm __/__/___ ___ mm ☐ Negative ☐ Positive
If PPD positive (≥10 mm), is the patient free of TB symptoms? ☐Yes ☐No Treated? ☐Yes ☐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 __/__/___	☐ Negative ☐ Positive ☐ Normal ☐ Findings:
Adult Tdap (Tetanus, Diphtheria & Acellular Pertusis) (Adacel or Boostrix)	__/__/___	
Varicella (chicken pox) vaccine *or* Varicella serologic immunity (attach lab report)	 __/__/___ *Dose1* __/__/___ *Dose 2*	Antibody __/__/___ ☐ Immune ☐ Non-immune
Annual flu (list vaccination for the current flu season)	__/__/___	
COVID-19 vaccine ☐ Pfizer ☐ Moderna ☐ J&J ☐ other: ☐ Pfizer ☐ Moderna ☐ J&J ☐ other: ☐ Pfizer ☐ Moderna ☐ J&J ☐ other:	__/__/___ __/__/___ __/__/___	

Healthcare provider name	Signature	Date

Revised 4.29.21

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Healthcare Provider Check List

Physical exam	Documentation of last physical exam (within past year); form included in packet as courtesy if needed
MMR	☐ 2 doses of Measles, Mumps, and Rubella vaccine ***OR*** ☐ MMR IgG titers showing immunity – **attach lab report** LabCorp test #058495 Quest Diagnostic test #85803A
Meningitis ACYW **Meningitis B**	☐ Meningitis ACYW (required for students under 19, first year college students in housing, those with asplenia, sickle cell, N meningitidis lab work, complement deficiency or complement inhibitor use, HIV,and travelers to/residents of areas with endemic meningitis)with at least 1 dose since age 16 ☐ Meningitis B (required for students with asplenia, sickle cell, *N meningitidis* lab work, complement deficiency or complement inhibitor use)
Hep B	☐ Hepatitis B Surface Antibody **QUANTITATIVE** titer (the result must be a number) **attach lab report.** LabCorp test # 006530 Quest Diagnostic test # 51938W ***Please draw a Hepatitis B Surface Antigen as well since it will have to besubmitted if the student fails to demonstrate immunity.*** ☐ Hepatitis B Surface Antigen **- attach lab report** LabCorp test # 006510 Quest Diagnostic test # 265F Please document all doses of Hepatitis B vaccine received on the immunization form **Options if a student is not immune:** **1. Booster dose, followed by titers one month after, or** **2. Repeat the series, followed by titers one month after** These are CDC recommendations for all healthcare workers. The student will not be permittedto matriculate without these tests.
PPD	☐ 2-step PPD* (1-3 weeks apart) **regardless** of history of BCG • Please include date placed and date read in millimeters of induration • For a PPD ≥10 mm now or in the past, you must submit documentation of the PPD reading and a chest x-ray or FDA approved blood test within the last 6 months ***OR*** ☐ an FDA approved blood test for TB (such as Quantiferon Gold) LabCorp test # 182873 Quest Diagnostic test # 19453
Tdap	☐ Adult Tdap (tetanus/diphtheria/**acellular pertussis**) (Adacel/Boostrix) (one-time administration)
Varicella	☐ 2 doses of Varicella vaccine, at least 1 month apart ***OR*** ☐ Varicella IgG titer showing immunity- **attach lab report** LabCorp test # 096206 Quest Diagnostic test # 54031E
COVID-19 vaccine	Please document all doses of COVID-19 vaccines.

***** Students working in healthcare with documented annual PPDs may submit that documentation to fulfil this requirement.

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School of Nursing: **TELEHEALTH** Health History and Physical Form

PART I: To be completed by the student. Please print or type.						
Last name	First name	MI	School/Grad year/program:			
DOB (month day year)	☐ Male ☐ Female	Street Address		City	State	Zip
Telephone (cell)	Email					
HEALTH HISTORY (attach pages as needed)						
Ongoing health problems	Past surgeries	Allergies	Medications taken regularly			

Telehealth Physical Form - PART II: To be completed by the healthcare provider.		
TELEHEALTH PHYSICAL EXAM (Must be completed by a non-relative physician, nurse practitioner, or physician's assistant)		
Exam date:		
Patient Reported Height (inches):	Weight (pounds):	
	Normal	If abnormal, please explain:
General appearance	☐ Well appearing in no acute distress	_____
Skin	☐ No apparent rashes, lesions, or skin defects	_____
Head	☐ Normocephalic, atraumatic	_____
Eyes	☐ EOMI. No redness, discharge or edema	_____
Neurological Exam	☐ Alert and oriented. Cranial nerves II-XII intact	_____
Respiratory	☐ No respiratory distress, wheezing or accessory muscle use	_____
Psychiatric Exam	☐ Cooperative with normal affect, speech and memory. No delusions or hallucinations.	_____
		_____
Any signs of substance abuse?	☐ Yes ☐ No	_____

Healthcare provider	Address/Stamp
Print name	
Signature	Phone
Date	Fax