

Student Health Services, Piscataway Campus Family Medicine at Monument Square 317 George Street, Suite 100, New Brunswick, NJ 08901 p 732-235-5160 f 732-235-7351

Dear Incoming 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 to have your health care provider complete, sign and date the Immunization Record and attach all relevant labs. Give the Healthcare Provider Checklist to your healthcare provider so that the appropriate tests are performed. Your provider may not be familiar with some of these requirements, but they are, in fact, **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 Immunization Portal at <u>rutgers.medicatconnect.com</u> 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. Student Health Services will be prepared to administer any missing immunizations or testing if required.

The RBHS "Student Immunization & Health Requirements" Policy may be accessed at here.

If for religious, health, or other reasons, you have not been completely immunized, please provide official verification for requesting an exemption from this requirement. Medical exemptions require a physician's verification. If you have any questions, require additional information, or need a recommendation for a local health care provider, please contact Student Health Services at: 732-235-5160 or email at jb1481@rwjms.rutgers.edu. If you are unable to access the Immunizations Portal, you may fax or mail the completed forms, but please note that you will still need to complete the Mandatory Health Form online. Be sure to keep a copy of your paperwork for your own records.

Sincerely,

Komal Bhatt M.D. Medical Director



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Use your Rutgers login to upload this completed and signed form into http://rutgers.medicatconnect.com Questions? Email jb1481@rwjms.rutgers.edu

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) va	ccine	// Dose 1	Measles □Immune □Non-immune
or		// Dose 2	Mumps □Immune □Non-immune
serologic immunity (attach lab report)		_/_/	Rubella
Meningitis ACYW		_/_/	□Menveo □Menactra □Menomune
(required for ALL students under 19, f		_/_/	■Menveo ■Menactra ■Menomune
housing, those with risk factors ^{1,2,} and	specific travelers³)		
with at least 1 dose since age 16			
Meningitis B (required for students with risk fa		//	□Trumenba □Bexero
¹asplenia, sickle cell, N meningitidis lab work, compl		_/_/	□Trumenba □Bexero
complement inhibitor use ² HIV ³ travelers to/reside	ents of areas with endemic	_/_/	□Trumenba □Bexero
meningitis QUANTITATIVE Hepatitis B Surface Antibody			
qualitative will not be accepted per CI			Hep B Surface Antibody/_/
We recommend submitting a Hepatitis B Surface An	•		Immune (≥10 mIU/mL)
is not demonstrated (attach lab reports). If starting			□ Non-immune
required prior to enrollment.	tire series, at least 1 dose is		■ Non-initialie
	■Heplisav ■Twinrix	/ / Dose 1	Hep B Surface Antigen//
	∃Heplisav □Twinrix	/ / Dose 2	■ Negative
_	∃Heplisav □Twinrix	//Dose 3	□ Positive
Tuberculosis	·	PPD placed	PPD read induration
Two PPDs or an FDA approved blood	test are required regardless	PPD #1//	/ / mm
of prior BCG within the past 6 months		PPD #2 / /	_/_/ mm
or	of matriculation	110#2//	//
FDA approved blood test (attach lab r	eport)	_/_/	☐ Negative ☐ Positive
If PPD positive (≥10 mm), is the patient free of	TB symptoms? □Yes □No		
Treated? □Yes □No		Blood test	
For positive PPD: a normal chest x-ray or negat	tive FDA approved blood	_/_/	☐ Negative ☐ Positive
test is required within the past 6 months (attac	ch report). For positive TB	Chest x-ray	
blood test: a chest x-ray is required within the	past 6 months (attach	_/_/	☐ Normal ☐ Findings:
report)			
Adult Tdap (Tetanus, Diphtheria & Acellular Pe	ertusis) (Adacel or Boostrix)	//	
Varicella (chicken pox) vaccine			Antibody/
or		//Dose1	☐ Immune
Varicella serologic immunity (attach lab re	port)	// Dose 2	☐ Non-immune
Annual flu (list vaccination for the current	flu season)	//	
COVID-19 vaccine ☐ Pfizer ☐ Modern	•	/ /	
☐ Pfizer ☐ Modern			
□ Pfizer □ Modern			
Healthcare provider name	Signature	<u> </u>	Date
Treatmente provider flame	J.B. Ideal C		Date

Last name

Healthcare provider

Print name

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First name

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Date

RUID or A number

Immunization Record

DOB (month day year)

	-	_	le copy. We recommend submitting sters during your time at Rutgers.
		D	ate (mo day yr)
Hepatitis A		_	_//_ _//_
Human Papilloma Virus	☐ Gardisil 4 Gardasil 9 ☐ Gardisil 4 Gardasil 9 ☐ ☐ Gardisil 4 Gardasil 9 ☐	l Cervarix	_//_ _//_ _//_
Japanese Encephalitis		-	_//_
Pneumococcal	□ PCV13	☐ PPSV23	_//_ _//_ _//_ _//_
Polio booster		_	_//_
Rabies vaccine			_//_ _//_ _//_
Typhoid □ TyphIM □ Vivotif (most recent dose)			_//_
Yellow Fever		_	_//

Signature



Healthcare Provider Check List

Mandatory Health Form	☐ Students must complete the ONLINE Mandatory Health Form at https://rutgers.medicatconnect.com/					
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 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	☐ Meningitis B (required for students with asplenia, sickle cell, <i>N meningitidis</i> lab work, complement deficiency or complement inhibitor use)					
	Hepatitis B Surface Antibody QUANTITATIVE titer (the result must be a number) attach lab report. Lab Corp test # 006520. Overt Discrepation test # 51038W.					
Нер В	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 permitted to 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)					
Tdap	LabCorp test # 182873 Quest Diagnostic test # 19453 Adult Tdap (tetanus/diphtheria/acellular pertussis) (Adacel/Boostrix) (one-time administration)					
Тиар						
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	Please document all doses of ACIP-approved COVID-19 vaccines.					

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



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Physical Examination

Name			DOB			Date of Evaluation
Height	Weight	BM	IP	ulse	_BP	
Visual Acuity R_	L					
Normal $()$						
		Normal	Abnormal	Comm	ents	
General Appeara						
Ears, Nose, Thro						
Eyes, EOMI, PEI	RLA					
Neck, Thyroid						
Chest Wall						
Lungs						
Heart						
Breasts						
Abdomen						
Genital System						
Extremities						
Skin						
Psychologic						
Vascular/Lympha	atic					
Neurologic						
Healthcare Provide	der Name Prin	ted	Sigr	nature		
Office Stamp wit	h Addraga					
Office Stamp Wil	II Address					

Please note: Disclosure of a disability on this form is not deemed to be notice to the University of a request for accommodations.