RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

STEP 2 OF 4

IMMUNIZATION PACKET
- Type in your information
- Print out
- Give to your health provider to complete
- **Fall Semester Deadline:** August 1st
- **Spring Semester Deadline:** January 5th

Use your Rutgers login to upload this completed and signed form onto https://rutgers.medicatconnect.com/
Questions? email vaccine@echo.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) 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** **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*	__/__/___ __/__/___ __/__/___ __/__/___ __/__/___	☐Menveo ☐Menactra ☐Menomune ☐Menveo ☐Menactra ☐Menomune ☐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* *F*DA 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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Last name	First name	DOB (month day year)	RUID or A number

PART III: Additional vaccinations: Please complete or attach a legible copy. We recommend submitting this information so we can better care for you at our health centers during your time at Rutgers.

		Date (mo day yr)
Hepatitis A		__/__ /__ __/__ /__
Human Papilloma Virus	☐ Gardisil 4 Gardasil 9 ☐ Cervarix ☐ Gardisil 4 Gardasil 9 ☐ Cervarix ☐ Gardisil 4 Gardasil 9 ☐ Cervarix	__/__ /__ __/__ /__ __/__ /__
Japanese Encephalitis		__/__ /__ __/__ /__
Pneumococcal	☐ PCV13 ☐ PPSV23 ☐ PCV13 ☐ PPSV23 ☐ PCV13 ☐ PPSV23 ☐ PCV13 ☐ PPSV23	__/__ /__ __/__ /__ __/__ /__ __/__ /__
Polio booster		__/__ /__
Rabies vaccine		__/__ /__ __/__ /__ __/__ /__
Typhoid	☐ TyphIM ☐ Vivotif (most recent dose)	__/__ /__
Yellow Fever		__/__ /__

Healthcare provider

Print name	Signature	Date

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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 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 ACIP-approved COVID-19 vaccines.

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