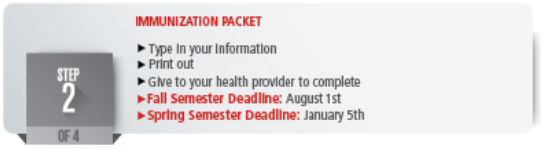
RUTGER
THE STATE UNIVERS OF NEW JERSEY



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**	__/__/___ __/__/___	☐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
Hepatitis B (if starting the series, at least one dose is required prior to enrollment) ☐Engerix ☐Heplisav ☐Twinrix ☐Engerix ☐Heplisav ☐Twinrix *or* ☐Engerix ☐Heplisav ☐Twinrix **QUANTITATIVE** Hep B Surface Antibody showing immunity (attach report)	__/__/___ *Dose 1* __/__/___ *Dose 2* __/__/___ *Dose 3* ☐ Immune (≥10 mIU/mL) ☐ Non-immune	

Tuberculosis: **please review with the student to assess need for tuberculin testing. Has the student:**	
1. Had close contact with persons known or suspected to have active TB disease?	☐Yes ☐No
2. Spent more than one month **OR** was born in: Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, North Korea, Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russia, Sierra Leone, South Africa, Thailand, Tanzania, Vietnam, Zambia or Zimbabwe	☐Yes ☐No
3. Lived in or been employed by a correctional facility, long-term care facility, or homeless shelter?	☐Yes ☐No
4. Volunteered or worked with clients/patients at increased risk for active TB disease?	☐Yes ☐No
If the answer is YES to any of the above questions, the student is required to submit TB testing from the past 6 months (through either a PPD or TB blood test, regardless of prior BCG). Please document testing below. **Has the student had a positive PPD or TB blood test in the past?** ☐Yes ☐No **If PPD positive (now or in the past), is the student free of TB symptoms?** ☐Yes ☐No	PPD Placed __/__/___ Read __/__/___ Induration ____ mm
Was the student 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)	TB blood test __/__/___ ☐Negative ☐Positive Chest x-ray __/__/___ ☐Normal ☐Findings:_____
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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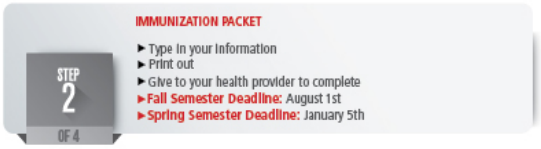

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Immunization Record

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)	Results (if applicable)
Adult Tdap ☐ Tdap ☐ Td	__/__ /__	
Varicella (Chicken Pox) Varicella Dose #1 Varicella Dose #2 ***OR*** Varicella serologic immunity (list date and attach lab report)	 __/__ /__ __/__ /__ __/__ /__	 ☐ Immune ☐ Non-immune
Annual flu (list vaccination for the current flu season)	__/__ /__	
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		

Cat 4 4.29.2021

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Healthcare Provider and student checklist (REQUIRED ITEMS)

Mandatory Health Form	☐ Students must complete an **ONLINE** Mandatory Health Form at https://rutgers.medicatconnect.com/
MMR	☐ 2 doses of Measles, Mumps, and Rubella vaccine (first dose must be after age 1) ***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, thosewith asplenia, sickle cell, N meningitidis lab work, complement deficiency or complementinhibitor 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	☐ Complete series of Hepatitis B vaccine (3 doses of Engerix or 2 doses of Heplisav) ***OR*** ☐ Hepatitis B Surface Antibody **QUANTITATIVE** titer (the result must be a number) **attach lab report**. LabCorp test # 006530 Quest Diagnostic test # 51938W
PPD	Students are assessed for tuberculosis risk through a series of questions on the online Mandatory Health Form (also listed on the immunization record). Students with past or current risk will need to submit either a single PPD or FDA approved blood test. Testing must occur **regardless** of receiving BCG in the past. The questions are listed in the Immunization Record. ☐ PPD • 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	This vaccination is highly recommended once after age 19 for everyone. If you will be spending time in a lab or a clinical environment, it is your responsibility to obtain this vaccination. ☐ Adult Tdap (tetanus/diphtheria/**acellular pertussis**) (Adacel/Boostrix) (one-time administration)
Varicella	Please document the student's varicella vaccination or titer if known.
COVID-19 vaccine	Please document all doses of ACIP-approved COVID-19 vaccines.

***** Students working in healthcare with two or more up-to-date annual PPDs may submit that documentation to fulfil this requirement.