

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 at an increased cost to you, as any cost incurred related to the above requirements is your responsibility.

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

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"/> Engerix <input type="checkbox"/> Heplisav <input type="checkbox"/> Twinrix <input type="checkbox"/> Engerix <input type="checkbox"/> Heplisav <input type="checkbox"/> Twinrix <input type="checkbox"/> Engerix <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 |

