RUTGERS
School of Dental Medicine

Office of Continuing Dental Education
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MEMORANDUM

**To:** CDE Participants in Hands-on Courses

**From:** Janice Gibbs, MA
Director, Continuing Dental Education

**Re:** Rutgers Policy on Student Immunizations & Health Requirements

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Participants in Continuing Dental Education activities that involve any kind of patient contact are required to follow the Rutgers policy for immunizations and health requirements. The policy can be viewed on-line at:

Student Immunization and Health Requirements

The forms in this package are to be completed in accordance with the chart, Exhibit A, found on page 8 of the policy. Please follow the guidelines for patient contact, with risk of exposure. Also see the attached Health Care Provider Check List.

In order to protect your privacy please seal the fully completed, original, signed forms in an envelope with your name, the Continuing Dental Education course title or code and the words "health forms" written on the outside. This envelope should then be placed inside another envelope and mailed to us at:

Rutgers School of Dental Medicine
Continuing Dental Education
Attn: Corinne Fogarty
110 Bergen Street, B701
Newark, NJ 07103

Please remember to keep a copy for your own files.

Documents will be reviewed by the Rutgers Student Health Services.

# ☑ Health Care Provider Check List

**These requirements can take substantial time to complete, so please obtain immunizations and required tests right away.**

☐ Adult Tdap (tetanus/diphtheria/acellular pertussis) (Adacel) (one-time administration)

☐ 2 doses of Measles vaccine, or a Rubeola IgG titer showing immunity- **attach lab report**
LabCorp test # 096560 .....Quest Diagnostic test # 52449W

☐ 1 dose of Mumps vaccine, or a Mumps IgG titer showing immunity**- attach lab report**
LabCorp test # 096552 .....Quest Diagnostic test # 64766R

☐ 1 dose of Rubella vaccine, or a Rubella IgG titer showing immunity**- attach lab report**
LabCorp test # 006197 .....Quest Diagnostic test # 83626F

☐ 2 doses of MMR satisfies above requirement for measles, mumps and rubella

☐ 2-step PPD ***** regardless of history of having received BCG

- Please include date read with mm. (millimeters) of induration
- For a positive PPD (≥10 mm.), you must submit the date and size of induration, and a chest x-ray report from within the past 12 months

**Or** - QuantiFERON-TB Gold test – **attach lab report**

☐ 3 doses of Hepatitis B vaccine are required. If all 3 doses have previously been received, please provide a **QUANTITATIVE** Hepatitis B Surface Antibody titer immunity**- attach lab report**
LabCorp test # 006395 .....Quest Diagnostic test # 51938W

☐ Hepatitis B Core Antibody and Hepatitis B Surface Antigen titers are **<u>required</u>- attach lab report**
**This is a CDC recommendation for all healthcare workers. Your patient will not be permitted to matriculate without these tests.**
LabCorp Hep B Core Antibody Total test # 006718 Quest Diagnostic test # 51870E
LabCorp Hep B Surface Antigen test # 006510 Quest Diagnostic test # 265F

☐ 2 doses of Varicella vaccine or a Varicella IgG titer showing immunity**- attach lab report**
LabCorp test # 096206 .....Quest Diagnostic test # 54031E

☐ Influenza vaccine during the flu season (optional).

***From MMWR: Guidelines for Preventing The Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005.**

Two-step testing is recommended for healthcare workers (HCWs) whose initial Tuberculin Skin Test (TST)(PPD) results are negative. If the first-step TST result is negative, the second-step TST should be administered 1- 3 weeks after the first TST result was read. If either 1) the baseline first-step TST result is positive or 2) the first-step TST result is negative but the second-step TST result is positive, TB disease should be excluded, and if it is excluded, then the HCW should be evaluated for treatment of latent TB infection (LTBI). If the first and second-step TST results are both negative, the person is classified as not infected with M. tuberculosis.

**RUTGERS – STUDENT HEALTH SERVICES**

**IMMUNIZATION RECORD**

Last Name _____ First _____

Address _____ Home Phone _____

City _____ State NJ Zip _____ Cell Phone _____

Date of Birth _____ E-mail Address _____

School/Program **Rutgers School of Dental Medicine – Continuing Dental Education**

Program Start Date: _____ End Date: _____

**To Be Completed and Signed by Your Health Care Provider**

**ALL ITEMS MUST BE COMPLETED**

| | Health Svc Use Only | |
|---|---|---|
| | Need | OK |

**A. ADULT Tdap (Tetanus, Diphtheria & Acellular Pertussis) Adacel™** _____ ___/___/___ (M D Y) — **A**

**B. MMR (Measles, Mumps, Rubella)** — **B**

1. Dose 1 given at 12 months after birth or later, and Dose 2 after 1980 #1. ___/___/___ (M D Y) #2. ___/___/___ (M D Y)

**– OR – INDIVIDUAL MMR AS SPECIFIED IN C, D and E:**

**C. MEASLES (Rubeola)** (2 Doses of Live Vaccine Required) — **C**

1. Dose 1 of live vaccine at 12 months after birth or later and Dose 2 after 1980 #1. ___/___/___ (M D Y) #2. ___/___/___ (M D Y)

**– OR –**

2. Serologic immunity. **(Attach lab report & record date of lab test)** _____ ___/___/___ (M D Y)

**D. RUBELLA (German Measles)** — **D**

1. Live vaccine at 12 months after birth or later _____ ___/___/___ (M D Y)

**– OR –**

2. Serologic immunity. **(Attach lab report & record date of lab test)** _____ ___/___/___ (M D Y)

**E. MUMPS** — **E**

1. Live vaccine at 12 months after birth or later _____ ___/___/___ (M D Y)

**– OR –**

2. Serologic immunity. **(Attach lab report & record date of lab test)** _____ ___/___/___ (M D Y)

**F. TUBERCULOSIS –** PPD required ***regardless*** of prior BCG — **F**

**If Result #1 < 10 mm, PPD #2 must be done 1-3 weeks later.**

1. **PPD (2 STEP)** Result #1: _____mm induration (horizontal diameter). Date read: ___/___/___ (M D Y)

   Result #2: _____mm induration (horizontal diameter). Date read: ___/___/___ (M D Y)

2. **For PPD's ≥ 10mm** mm induration: _____ Date read: _____

   Was INH taken? ☐ Yes ☐ No How long? _____

3. If ≥ 10mm, chest X-ray required within past 12 months **(attach report)** ___/___/___ (M D Y)

**G. VARICELLA (Chicken Pox)** — **G**

1. 2 Doses required. #1. ___/___/___ (M D Y) #2. ___/___/___ (M D Y)

**– OR –**

2. Serologic immunity. **(Attach lab report & record date of lab test)** _____ ___/___/___ (M D Y)

***Continued on next page***

***Return all original forms in a sealed envelope marked "Confidential" to:***

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**RUTGERS – STUDENT HEALTH SERVICES**

**IMMUNIZATION RECORD**

*Continued from previous page*

Last Name _____ First _____

| | Need | OK |
|---|---|---|
| **H. Hepatitis B –** At Least two of three doses are required prior to start of school: #1. ___/___/___ #2. ___/___/___ #3. ___/___/___ (M D Y) | H | |
| **I. Hepatitis B Surface Antibody Titer** – Titer must be QUANTITATIVE not qualitative. Required 1-2 months after dose #3 **(attach lab report & record date of lab test)** _____ ___/___/___ (M D Y) | I | |
| **J and K are required, regardless of vaccination history** | | |
| **J. Hepatitis B Core antibody must be IgG or Total (attach lab report & record date)** _____ ___/___/___ (M D Y) | J | |
| **K. Hepatitis B Surface antigen (attach lab report & record date)** _____ ___/___/___ (M D Y) **If K is positive, must include L** | K | |
| **L. Hepatitis B antigen (HBeAg) (attach lab report & record date)** _____ ___/___/___ (M D Y) L required only if K is positive | L | |
| **M. Meningococcal vaccine** (required for Rutgers housing application processing) _____ ___/___/___ (M D Y) | M | |
| **N. Complete Meningococcal Meningitis Response Form (separate form, attach)** | N | |

**HEALTH CARE PROVIDER (must be completed)**

Print Name _____ Address _____

Signature _____

Date _____ Phone _____

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