THE LEADER IN GLOBAL EDUCATION

FAIRLEIGH DICKINSON UNIVERSITY

Student Health Services
Florham Campus

Student Health Services
Florham Campus
285 Madison Avenue, M-WE0-01
Madison, NJ 07940-1006
Phone: (973) 443-8535
Fax: (973) 443-8174

Dear Nursing Student,

The Student Health Service staff welcomes you to the University and we offer our support in any way possible during your study at Fairleigh Dickinson University. If you have special needs or require assistance with a medical problem, please do not hesitate to contact us before your arrival.

Enclosed you will find the required health forms and immunization requirements (5 pages). **(A)** Please complete the Student Profile, Medical History, and Meningitis Response Form yourself. **(B)** Your health professional will need to complete the Physical Examination and the Immunization Record forms.

Please complete all required Medical forms and Immunization requirements. In addition, you must also have blood titers done for MMR, Varicella (chicken pox), and Hepatitis: (HepBsAg, HepBcore IgM Ab and HepBsAb) and a twostep Mantoux (TB). Submit a copy of all titers with your medical admission forms. Please understand that you will not be permitted to register for class, clinicals or reside in FDU housing until the health forms and immunization records are completed and received. Completed health forms are due:

- July 15th for Fall
- December 1st for Spring
- April 15th for Summer

We strongly recommend that you keep a copy of your immunization records. Medical records are strictly confidential and are used exclusively by the Student Health Service to provide personalized care. Immunization records are an exception and are not confidential since your immunization status must be made available to state inspectors and select University offices in order to comply with New Jersey state law.

Please forward your completed Medical forms to the address below:

Student Health Service
FDU Florham Campus
285 Madison Avenue, M-WE0-01
Madison, NJ 07940-1006
(973) 443-8535 (voice)
(973) 443-8174 (fax)

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FAIRLEIGH DICKINSON UNIVERSITY
Student Health Services
Florham Campus

Nursing Student Immunization Record

NOT CONFIDENTIAL

Immunization records are not confidential as required by law

Name: _____ Male ___ Female __
Last First Middle

Student ID #: _____ Date of Birth: _____

THIS FORM IS TO BE COMPLETED & SIGNED BY A HEALTH CARE PROVIDER. (GIVE MONTH, DAY & YEAR)

If convenient, you mat attach an official copy of your immunization records, which must include previous and recent shots

1. Required Immunizations (Laboratory Report Must Be Submitted for All Blood Titers)

MMR #1_____ #2_____
NOTE: Measles has to be live after 1st birthday

Measles #1_____ #2_____

Mumps #1_____ #2_____

Rubella #1_____ #2_____

MMR Titers

Date_____ Immune___ Non-Immune___

Date_____ Immune___ Non-Immune___

Date_____ Immune___ Non-Immune___

Varicella (Chicken Pox) Disease Date_____

OR Vaccine #1_____ #2_____

Varicella Titers

Date_____ Immune___ Non-Immune___

Hepatitis B #1_____ #2_____

#3_____

Meningococcal Containing Vaccine Date_____
*(**Required for all residents**; recommended for All students)*

Adult Tdap Date_____

Influenza Vaccine Date_____

Hepatitis B Titers

HepBsAg Date_____

Positive ____ Negative ____

HepB core IgMAb Date_____

Positive ____ Negative ____

HepBsAb Date_____

Positive ____ Negative ____

2. Tuberculosis Test (Must be within the 6 months prior to the start date of student's first semester

Mantoux/PPD Test
#1 Date Given_____ Date Read_____ Result: Negative ___ Positive ___ Size _____mm (induration)
Nursing Students require a two-step Mantoux. This second step must be 1-3 weeks after the first.

#2 Date Given_____ Date Read_____ Result: Negative ___ Positive ___ Size _____mm induration)

If Mantoux (PPD) is Positive, please complete the Positive TB Test Checklist (CXR REQUIRED)
(Required for Positive Mantoux Result)

Signature of Medical Provider:_____ Date:_____ License Number

Medical Provider:_____ Phone:_____ OR

Address:_____ Official Stamp

Remember! Proof of Immunity is required prior to registration.
You will be put on medical hold unless you meet all entrance requirements

Rev 01/18

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FAIRLEIGH DICKINSON UNIVERSITY

Student Health Services
Florham Campus

Physical Examination

CONFIDENTIAL - TO BE COMPLETED BY A HEALTH CARE PROVIDER

Rev. 6 (2015-09-10)

Name: _____ Male ☐ Female ☐
Last *First* *Middle*

Student ID: _____ Date of Birth: _____ m m d d y y y y

MEDICAL INFORMATION

Blood Pressure _____ **Height** _____ **Weight** _____ **Pulse** _____

SYSTEMS REVIEW (If abnormal was checked, please comment)

System	Normal	Abnormal	Comments
Eyes			[Vision: Glasses / Contacts]
Head, Ears, Nose, Throat			
Respiratory			
Cardiovascular			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Gynecological			

ALLERGIES / MEDICAL & PSYCH. CONDITIONS / RECOMMENDATIONS

Allergic reactions to medications: (Please list)	
Food, insect or environmental allergies: (List all)	
Medical condition(s) requiring ongoing care: (Include letter from M.D.)	
Psychiatric conditions(s) requiring ongoing care: (Include letter from M.D.)	

Physical Activity (PE, intramurals): Unlimited ☐ Limited ☐ [Explain: _____]

Do you have any recommendations regarding the care of this student? Yes ☐ No ☐
[If Yes, Explain: _____]

Does this student have special needs that require accommodations including but not limited to academics, housing, dietary, or transportation? Yes ☐ No ☐ [If Yes, please include supporting documentation]

Student Nurses: Any use of non-prescribed or illegal substances which may impair their ability to perform safely as a Student Nurse?
Yes ☐ No ☐

Medications

Diagnosis	Medication	Dosage	Prescribing Physician

Psychotropic Medications

Diagnosis	Medication	Dosage	Prescribing Physician

Signature of Medical Provider: _____ Date: _____

Medical Provider: _____ Phone: ( ) _____

Address: _____

License Number
OR
Official Stamp of
Medical Provider

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FAIRLEIGH DICKINSON UNIVERSITY

Student Health Services
Florham Campus

Student Profile

CONFIDENTIAL
Information used solely to provide necessary health care

Rev. 6 (2015-09-10)

STUDENT PROFILE (To be completed by the student in ink)

Name: _____ Male ☐ Female ☐
Last *First* *Middle*

Student ID: _____ Date of Birth: _____ m m d d y y y y

Date entering FDU: _____ m m y y y y Citizenship: _____

Admission Status: Undergraduate ☐ Graduate ☐ International ☐ Transfer ☐ Nursing ☐ Athlete ☐

Mailing Address: _____
Street Address *City* *State* *Zip Code*

Home Phone: ( ) _____ Cell Phone: ( ) _____ E-Mail: _____

Father's/ Legal Guardian's Name: _____ Phone: ( ) _____

Mother's/ Legal Guardian's Name: _____ Phone: ( ) _____

Where do you plan to live? Resident ☐ Commuter ☐ (If are a commuter, provide the address where you will reside)

Address: _____ Phone: ( ) _____
Street Address *City* *State* *Zip Code*

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____
Street Address *City* *State* *Zip Code*

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

HEALTH/HOSPITALIZATION INSURANCE

Insurance Company Name: _____Policy # _____ Group # _____

Address: _____ Phone: ( ) _____
Street Address *City* *State* *Zip Code*

Is the student the insured? Yes☐ No☐ [If No, Name of Insured: _____ Relationship: _____]

FDU Student Insurance? Yes ☐ No ☐ FDU Student Insurance is **required** for all International Students.

All full-time undergraduate and graduate students enrolling in the Fall and Spring semester who wish to waive University coverage must provide evidence of comparable health medical expense coverage. Insurance premium is included in the college fees each semester. Proof of comparable coverage is required by the Higher Education Restructuring Act of 1994. ***Insurance waiver cards are available in Enrollment Services and must be submitted to Enrollment Services.****

Permission for medical care:
I authorize Fairleigh Dickinson University Student Health Services to provide medical services and when circumstances require immediate action, to notify the emergency contact. Yes ☐ No ☐

Permission for use of e-mail address:
I authorize Fairleigh Dickinson University Student Health Services to use my e-mail address. Yes ☐ No ☐

Student Signature: _____ Date: _____

If student is under 18 years of age:
Parent/Guardian Signature: _____ Relationship: _____ Date: _____

Records are due: July 15th for Fall, December 1st for Spring, April 15th for Summer

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Medical History

CONFIDENTIAL
To be completed by the student.

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Name: _____ *Male* ☐ *Female* ☐
Last *First* *Middle*

Student ID: _____ Date of Birth: _____ m m d d y y y y

FAMILY HISTORY (Check all that apply.) (Please use COMMENTS section if additional details are needed for clarification.)

Condition	Mother	Father	Sibling	Condition	Mother	Father	Sibling
Alcohol/Drug abuse	☐	☐	☐	High Blood Pressure	☐	☐	☐
Asthma	☐	☐	☐	Kidney Disease	☐	☐	☐
Cancer	☐	☐	☐	Mental/Emotional Illness	☐	☐	☐
Deceased (age)	☐	☐	☐	Stroke	☐	☐	☐
Heart Disease	☐	☐	☐	Tuberculosis	☐	☐	☐

PERSONAL HEALTH HISTORY (Check YES or NO.) (Please use COMMENTS section if additional details are needed.)

	YES	NO		YES	NO		YES	NO
Abusive/controlling relationship			Gallbladder trouble			Operations or serious injury (list details below)		
Alcohol/drug abuse			Head injury			Pneumonia		
Anemia			Heart disease/problems			Paralysis		
Arthritis			Hepatitis/jaundice			Psychological problems		
Asthma			High blood pressure			Rheumatic fever		
Bronchitis			HIV/AIDS			Self-harming behavior		
Cancer			Hospitalization (list details below)			Sexually transmitted disease		
Chicken Pox, if yes then date: _____			Intestinal/stomach trouble			Sickle cell trait/anemia		
Convulsions/seizures			Kidney disease/bladder problems			Sinus trouble		
Diabetes			Lyme disease			Skin disorder		
Disability (Physical or Learning)			Menstrual problems			Sleep difficulties		
Ear trouble/hearing loss			Migraine headaches			Smoking/tobacco use		
Eating disorder			Mononucleosis			Thyroid disease		
Eye disease/vision problems			Muscle, joint/bone disorder			Tuberculosis		

Are there other aspects of your health that might cause problems for you or require special accommodations (including academics, housing, dietary, and transportation) at FDU? If so, please specify._____

MEDICATIONS TAKEN REGULARLY (Include ALL prescription medications.)

_____ _____
Medication/Dosage/Frequency *Medication/Dosage/Frequency*

DRUG ALLERGIES *(Please specify.)*

_____

ALLERGIES (Please specify; include food, insect, and environmental allergies.)

_____

COMMENTS (If needed, please continue COMMENTS section on the back of this page.)

_____

I _____ declare that all of the above information is true to the best of my knowledge.
Print Name

Student Signature: _____ Date: _____

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FAIRLEIGH DICKINSON UNIVERSITY

Meningitis Response

Rev. 2017-5-17

IMPORTANT INFORMATION *(Please Read)*

Name: _____ Male ___ Female ___
Last First Middle

Student ID: _____ Date of Birth _____

MENINGITIS VACCINATION INFORMATION

Meningococcal disease can be devastating and often-and unexpectedly-strikes otherwise healthy people. Although meningococcal disease is uncommon, teens and young adults 16 through 23 years old (not just those in college) are at increased risk. Meningococcal bacteria can cause severe disease, including infections of the lining of the brain and spinal cord (meningitis) and bloodstream infections (bacteremia or septicemia), and can result in permanent disabilities and even death. Common symptoms are: confusion, fatigue (feeling very tired), rash of dark purple spots, sensitivity to light, stiff neck, vomiting, headache, high fever, nausea.

Anyone can get meningococcal disease, but certain groups are at increased risk. These include:

- College students and military recruits living in dorms or barracks
- People with certain medical conditions or immune system disorders including a damaged or removed spleen
- People who may have been exposed to meningococcal disease during an outbreak
- International travelers

Meningococcal bacteria are spread person-to-person through the exchange of saliva or nasal secretions. The bacteria are not spread by casual contact or by breathing the air where a person with meningococcal disease has been. One must be in direct (close) contact with an infected person's secretions in order to be exposed. Close contact includes activities such as: living in the same household, kissing, sharing eating utensils, food, drinks, cigarettes, etc.

The best way to prevent meningococcal disease is to get vaccinated. There are two kinds of vaccines in the United States that protect against 4 types of meningococcal disease known as A/C/Y/W-135. Two doses are recommended for all adolescents. The first dose is recommended at 11-12 years of age. Since protection wanes, a booster dose is recommended at age 16 years so adolescents continue to have protection during the ages when they are at highest risk of meningococcal disease.

Meningococcal vaccines are safe and effective. As with all vaccines, there can be minor reactions, including pain and redness at the injection site or a mild fever for one or two days. Severe side effects, such as a serious allergic reaction, are very rare. It is important to know that 1) no vaccine offers 100% protection, 2) protective immunity declines 3-5 years after the first dose of meningococcal vaccine and a booster dose is needed to provide continued protection; 3) Meningococcal Meningitis A/C/Y/W-135 vaccine contains only 4 of the 5 most common types of meningococcal disease and; 4) not all cases of meningitis are caused by meningococcal bacteria. Symptoms of meningitis in a vaccinated person should always warrant immediate medical attention regardless of vaccination.

Where can I get more information about meningococcal vaccine?

Your Healthcare Provider, and
Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/meningococcal/index.html

RESPONSE (If you have received the vaccine, provide verification of the same on proof of immunizations – not on this form)

Having read the above information, please check one of the following:

- ___ I am a Resident Student and have received the vaccine on _____
- ___ I have already received the meningitis vaccine within the past five (5) years on _____
- ___ I do not wish (my student) to receive the vaccine (Commuters Only).
- ___ I have decided to receive the meningitis vaccine at some future time (Commuter Only).

Student Signature: _____ Date: _____

If student is under 18 years of age, sign and date:

Parent/Guardian Signature: _____ Relationship: _____

Meningitis Vaccine is Mandatory for Students in University Housing

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Symptom Assessment for Pulmonary Tuberculosis (TB)

Name: _____
Last First FDU Student ID#

Date of Birth: _____/_____/_____ **Phone:** ( ) _____
Month Day Year

Date of Symptom Assessment: _____/_____/_____
Month Day Year

(*Check all TB- like symptoms that apply):*

☐Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)

☐Fever

□Coughing Up Blood (hemoptysis)

☐Chills

☐Unexplained Weight Loss (10 pounds or greater without dieting)

☐Chest Pain

☐Night Sweats (regardless of room temperature)

☐Very Easily Tired (fatigability)

☐Unexplained Loss of Appetite

☐*No TB-Like Symptoms Reported or Observed*

If any symptoms are reported, a chest radiograph is required.

Signature of Medical Provider: _____ **Date:** _____

Print Name: _____

Phone Number: _____

Address: _____

_____

OFFICE STAMP OR PROVIDER LICENSE NUMBER