

### STUDENT HEALTH SERVICES Metropolitan Campus

1000 River Road, T-SU2-03 Teaneck, New Jersey 07666 Phone: (201) 692-2437

Fax: (201) 692-2642

Dear Student,

The Student Health Services staff welcomes you to the University, and we offer our support in any way possible during your study at Fairleigh Dickinson University.

As all institutions of Higher Education have an obligation to ensure the public health of its students, we collect and review medical and immunization records for all matriculated FDU students. Your health care provider will need to complete the *Immunization Record* and *Physical Exam* forms included in the attached packet. The student is responsible to complete the *Student Profile*, *Medical History* and *Meningitis Response* forms.

DEPENDING ON WHAT TYPE OF STUDENT YOU ARE (RESIDENT, COMMUTER, NURSING, OFF-SITE), THERE ARE DIFFERENT REQUIREMENTS. PLEASE COMPLETE AND SUBMIT THE APPROPRIATE FORMS.

**OFF-SITE STUDENTS:** Students who are taking classes at an off-site location only need to submit the *Off-Site Student Immunization Record*. **If you are taking classes on the Metropolitan or Florham Campus you are NOT an Off-Site student.** You must submit the COMMUTER packet of forms.

Please understand that you will not be permitted to register for class until the health forms and immunization records are completed and received.

#### **Required Medical Entrance Forms due:**

• Fall Semester: July 15th

Spring Semester: December 15thSummer Semester: March 15th

Medical records are an entrance requirement for all incoming students. Required entrance forms are available on our website: **www.fdu.edu/shsmetro**. Please **MAIL** your completed forms to the address listed on the top of this page.

Medical records are strictly confidential and are not part of the academic records. Medical records are used exclusively by Student Health Services Metro to provide personalized care. Any information on these records or concerning a visit to Student Health Services Metro will not be released without written permission from the individual treated. Immunization records are an exception and are not confidential since your immunization status must be made available to New Jersey State Inspectors and select University offices in order to comply with New Jersey State Law. We strongly recommend that you keep a copy of your immunization records.



### **Student Profile**

CONFIDENTIAL

Information used solely to provide necessary health care.

Rev. 10 (2016-11-9)

STUDENT PROFILE (To be completed by the stud	ent in ink)						
Name:				Male 🗌	Female 🗌		
Student ID: Dat	First e of Birth:		ddle	· · · · · · · · · · · · · · · · · · ·			
Date entering FDU: Citiz	enship:						
Admission Status: Undergraduate Graduate	International	☐ Transfer [	Nursir	ng 🗌 Athl	ete 🗌		
Mailing Address:Street Address				C) I			
Home Phone: ( ) Cell Phone: (	)	City E-Mai	l:	State	Zip Code		
Father's/ Legal Guardian's Name:	<del> </del>		Phone: (	)			
Mother's/ Legal Guardian's Name:		1	Phone: (	)			
Where do you plan to live? Resident  Commuter	(Ifareac	ommuter, provi	de the ad	dress where	you will reside)		
Address:			Phone: (	)			
Street Address City	State	Zip Code		_			
PERSON TO CONTACT IN CASE OF EMERGENCY							
Name:		Kelationsi	nip:				
Address:Street Address		City		State	Zip Code		
Home Phone: ( ) Work Phone: (	)	•	one: (	)	<u>.                                    </u>		
AUTHORIZATIONS			-				
Permission for medical care: I authorize Fairleigh Dickinson University Student Healt	th Services to p	rovide medical s	services.	Yes[	□ No □		
To notify the above listed emergency contact, as deem	ed appropriate	·.		Yes	□ No□		
Permission for use of e-mail address:							
To communicate with me through the above listed e-mail address to use my e-mail address.  Yes No (the University will never communicate health information through e-mail and we strongly recommend that you don't either)							
					<u>.</u>		
Student Signature:		<del>.</del>	D	ate:			
If student is under 18 years of age:				<del></del>			
Parent/Guardian Signature:	Relation	ship:	0	Date:			
<u></u>							
Records are due: July 15 <sup>th</sup> for Fall semest	ter, Decemb	per 1 <sup>st</sup> for Sp	ring, A	pril 15 <sup>th</sup> f	or Summer		



### **Medical History**

#### CONFIDENTIAL

To be completed by the student.

Rev. 6 (2014-09-09)

Name:				· ·- ·-				Ma iddle	ile ∐ Fen	nale 📙	]
				First							
Student ID:				ра	te of Birth: _	1		HA YAU	·		
FAMILY HISTORY (Check	all that ap	ply.) (	Please	use COMN	IENTS section	n if ad	ditiona	I details are nee	ded for cla	rificati	on.)
Condition	Mother	Fa	ther	Sibling	Condition		_	Mother	Father	Sibli	ing
Alcohol/Drug abuse					High Bloo		ure				
Asthma					Kidney Di:						
Cancer					Mental/E	motion	al Ilines	s 🗆			
Deceased (age)					Stroke						
Heart Disease					Tuberculo	sis					
PERSONAL HEALTH HISTO	RY (Check	YES or	· NO) (F	lease use (	OMMENTS	section	n if add	litional details a	re needed.	)	
	YES	NO				YES	NO			YES	NC
Abusive/controlling			Gallbla	dder troub	le			Operations or :	serious		
relationship								injury (list deta	ils below)		
Alcohol/drug abuse			Head in	njury	·	ii		Pneumonia			
Anemia			Heart o	disease/pro	blems			Paralysis			
Arthritis			Hepati	tis/jaundice	2			Psychological problems			
Asthma			High blood pressure					Rheumatic feve	er		
Bronchitis			HIV/AIDS					Self-harming b	ehavior		
Cancer			Hospitalization (list details below)					Sexually transn disease	nitted		
Chicken Pox, if yes then date:			Intestinal/stomach trouble					Sickle cell trait,	<sup>/</sup> anemia		
Convulsions/seizures			Kidney disease/bladder problems					Sinus trouble			
Diabetes	<b></b>		Lyme disease					Skin disorder			
Disability (Physical or Learning)			Menstrual problems					Sleep difficultie	25		
Ear trouble/hearing loss			Migraine headaches					Smoking/tobac	co use		
Eating disorder			Monor	iucleosis				Thyroid disease	9		<u> </u>
Eye disease/vîsion problems				, joint/bon				Tuberculosis			
Are there other aspects of academics, housing, dietai											
MEDICATIONS TAKEN REG	<b>ULARLY</b> (lr	ıclude	ALL pre	escription n	nedications.	)					
6 A - J1 41 - 2m	/r						0=-1:	ion/Dosage/Frequ			
Medication/Dosage,						^	vieaicati	www.uosage/rrequ	ency		
DRUG ALLERGIES (Please s	pecify.)										
ALLERGIES (Please specify;	include fo	od, ins	ect, and	d environm	ental allergi	es.)					
COMMENTS (If needed, ple	ease contin	iue CO	MMEN	TS section (	on the back	of this	page.)			·	
						<del>-</del> -					
Print name			_ aeaa	ire macani	or tire above		acion i	J ti da to tile ba.	or Or my King	Jui Cab	Ψ.



# Physical Examination CONFIDENTIAL - TO BE COMPLETED

Rev. 16 (2014-09-09)

### BY A HEALTH CARE PROVIDER

Name:								Male 🗌	Female	
				First		Middle				
Student ID:				Date of Bi	rth:	<u>. 10. š. š</u>				
MEDICAL INFORMATIO									-	
		oight			Woight			ulse		
Blood Pressure					vveigiit					
SYSTEMS REVIEW (If abn										
System	Normal	Abnor	mal	Comment				-		
Eyes		<del> </del> _		[ Vision: G	lasses / Cor	itacts J				
Head, Ears, Nose, Throat										
Respiratory		<u> </u>		<del> </del>						
Cardiovascular		ļ			~					
Hernia	<del> </del>			<del> </del>		-	<u></u>			
Genitourinary				-						
Musculoskeletal					•					
Metabolic/Endocrine	<u> </u>									
Neuropsychiatric										
Skin										
Gynecological				<u></u>				<u></u> .		
ALLERGIES / MEDICAL & F	SYCH. CONDI	TIONS / R	RECON	MMENDATIO	NS					
Allergic reactions to medic	ations: (Please	e list)		-						
Food, insect or environme										
Medical condition(s) requi										
(Include letter from M.D.)	0 0									
Psychiatric conditions(s) re	equiring ongoir	ng care:		•						
(Include letter from M.D.)		-								
Physical Activity (PE, intramu	rals): Unlimited	Limit	ed 🗌	Explain:						]
Do you have any recommend	ations regarding	the care	of thic	student? Ves						
[If Yes, Explain:										1
- ,										—,
Does this student have specia							mics, ho	ousing, dieta	ry, or	
transportation? Yes	No [ ] [If Yes	s, please in	clude :	supporting do	cumentation	1]				
Student Nurses: Any use of n	on proscribed a	r illega! sul	hetane	es which may	impair their	ability to per	iorm saf	oly as a Stur	lent Nurs	۵?
	No	i iliegai sui	Datant	es willen may	mapan enen	ability to peri	Oitti Sui	ciy as a otac	iciic itaio	٠.
Medications								<del></del>		
Diagnosis		Medic	Medication		Dosage		Pres	cribing Phy	ysician	
<u> </u>										
							-			
<u></u> .										
Psychotropic Medications										
Diagnosis		Medication		n Dosage			Pres	cribing Phy	/sician	
					_			-	·	
<del></del>										
				<del>'</del>	D-1-			licon	se Numi	her
Signature of Medical Provider:			Date:				F10E112			
Medical Provider:				Ph	one: (	)			OR	æ
					1				al Stamp	
Address:								Medic	al Provi	der



## Meningitis Response IMPORTANT INFORMATION (Please Read)

Name:	Male Female
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/ClY/W-135. Two doses are recommended for alt adolescents. The first dose is recommended at f 1-12 years of age. Since protection wanes, a booster dose is recommended at age 1 6 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 I) 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/CIYIW- 1 35 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 htte://www.cdc.gov/meningococcal/index.html

Meningitis Vaccine is Mandatory for	Students in University Housing
Parent/Guardian Signature:	Relationship:
If student is under 18 years of age, sign and dote:	•
Student Signature:	Date:
• I have decided to receive the meningitis vaccine a	t some future time (Commuter Only).
<ul> <li>I do not wish (my student) to receive the vaccine (</li> </ul>	(Commuters Only).
<ul> <li>I have already received the meningitis vaccine wit</li> </ul>	• • • • • • • • • • • • • • • • • • • •
<ul> <li>I am a Resident Student and have received the vac</li> </ul>	
Having read the above information, please check one of the	following:
proof of immunizations	s — not on this form)
RESPONSE (If you have received the vacc	cine, provide verification of the same on
centers for Disease Control and Frevention (CDC) at in	tte.//www.ede.gov/inclangococca/indexatem



Metropolitan Campus

Address:

#### Resident Student Immunization Record

Rev.9 17 08 2017

**Medical Provider** 

NOT CONFIDENTIAL

Immunization records are not confidential as required by law.

Name:		Male	Female 🔲					
Last	First	Middle						
FDU Student ID#:	Date of Birth:	mm adyyy	<u>Y</u>					
TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR  If convenient, you may attach an official copy of your immunization records, which must include all previous/recent shots								
1. REQUIRED IMMUNIZATIONS (The titer report must be submitted for any blood titers)								
MMR #1#2	OR OR	Titers						
NOTE: MEASLES HAS TO BE LIVE, AFTER 1 <sup>ST</sup> BIRTHDAY			:					
Measles #1 #2	Date	Immune 🗌	Non-immune 🔲					
Mumps #1 #2	Date	Immune 🗌	Non-immune 🔲					
Rubella #1 #2	Date	Immune 🗌	Non-immune 🔲					
Varicella (Chicken Pox) Disease date:		Titers	_					
OR Vaccine #1 #2	Date	Immune	Non-immune					
Hepatitis B #1 #2	OR	Titers						
#3	Date	Immune 🗌	Non-immune 🗌					
Meningococcal Vaccine *Groups A,C,Y and W-135	Meningococcal Vaccine *Groups A,C,Y and W-135 - *REQUIRED FOR ALL STUDENTS LIVING IN THE DORMS							
Date:(WITHIN THE LAST 5 YEARS IS ACCEPTABLE)  PROOF OF A MENINGOCCOCAL (QUAD) VACCINE IS REQUIRED  REGARDLESS OF BEXSERO OR TRUMENBA VACCINES								
T-dap – Adult (within the last 10 years) date :( TD is not acceptable)								
2. TUBERCULOSIS TEST (within the last 6 mont	hs, regardless of a BCG vacc	ine)						
Mantoux/PPD Test:  Date Given Date Read	Result: Negative							
OR QuantiFERON-TB Gold or T-Spot Test:		(must be indic	ated)					
·	(MUST A	ATTACH LAB REPORT)						
If a TB Test is Positive, a Chest X-ray is required.								
Your physician may be required to complete a <u>Positive TB Test Checklist in its entirety</u> .  Please download the positive TB checklist form at http://view2.fdu.edu/dwnld/3863								
Signature of Medical Provider:	Date:	Lice	nse Number					
Medical Provider:	Phone: ( )	Offic	OR cial Stamp of					