



**FAIRLEIGH
DICKINSON
UNIVERSITY**

Student Health Services
Metropolitan Campus

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 15th**
- **Summer 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.

Rev. 2014-09-09

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/CIY/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 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/CIYW- 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 <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



Resident Student Immunization Record

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Student Health Services
Metropolitan Campus

NOT CONFIDENTIAL
Immunization records are not confidential as
required by law.

Name: _____ Male Female
Last First Middle

FDU Student ID#: _____ Date of Birth:

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	Titers
<i>NOTE: MEASLES HAS TO BE LIVE, AFTER 1ST BIRTHDAY</i>				
Measles	#1 _____	#2 _____	Date _____	Immune <input type="checkbox"/> Non-immune <input type="checkbox"/>
Mumps	#1 _____	#2 _____	Date _____	Immune <input type="checkbox"/> Non-immune <input type="checkbox"/>
Rubella	#1 _____	#2 _____	Date _____	Immune <input type="checkbox"/> Non-immune <input type="checkbox"/>
Varicella (Chicken Pox)	Disease date: _____		OR	Titers
OR Vaccine #1	#1 _____	#2 _____	Date _____	Immune <input type="checkbox"/> Non-immune <input type="checkbox"/>
Hepatitis B #1	#1 _____	#2 _____	OR	Titers
	#3 _____		Date _____	Immune <input type="checkbox"/> Non-immune <input type="checkbox"/>

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 MENINGOCOCCAL (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 months, regardless of a BCG vaccine)

Mantoux/PPD Test:

Date Given _____ Date Read _____ Result: Negative Positive Size _____ mm (induration)
OR (must be indicated)

QuantiferON-TB Gold or T-Spot Test:

Date _____ Result _____ (MUST ATTACH LAB REPORT)

If a TB Test is Positive, a Chest X-ray is required.

Your physician may be required to complete a Positive TB Test Checklist in its entirety.

Please download the positive TB checklist form at <http://view2.fdu.edu/dwnld/3863>

Signature of Medical Provider: _____	Date: _____	License Number OR Official Stamp of Medical Provider
Medical Provider: _____	Phone: () _____	
Address: _____		

**Proof of Immunity against all the above is required prior to registration.
You will be placed on medical hold unless you meet all entrance requirements.**