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.*

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Student Profile

CONFIDENTIAL

Information used solely to provide necessary health care.

Rev. 10 (2016-11-9)

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

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

Student ID: _____ Date of Birth: _____

Date entering FDU: _____ 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: ( ) _____

AUTHORIZATIONS

Permission for medical care:

I authorize Fairleigh Dickinson University Student Health Services to provide medical services. Yes ☐ No ☐

To notify the above listed emergency contact, as deemed 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)

Student Signature: _____ Date: _____

If student is under 18 years of age:

Parent/Guardian Signature: _____ Relationship: _____ Date: _____

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

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Medical History

CONFIDENTIAL

To be completed by the student.

Rev. 6 (2014-09-09)

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

Student ID: _____ Date of Birth: _____

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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Physical Examination

CONFIDENTIAL - TO BE COMPLETED BY A HEALTH CARE PROVIDER

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

Student ID: _____ Date of Birth: _____

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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Rev. 2017-06-22

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/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 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

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 dote:

Parent/Guardian Signature:_____Relationship:_____

Meningitis Vaccine is Mandatory for Students in University Housing

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Nursing Student Immunization Record

Rev. 10 (2014-09-09)

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

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

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

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 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 residents, recommended for ALL students)

Adult Tdap : Date _____

Influenza Vaccine: Date _____

Hepatitis B Titers

HepBsAg Date _____
Positive ☐ Negative ☐

HepBcore IgM Ab Date _____
Positive ☐ Negative ☐

HepBsAb Date _____
Immune ☐ Non-immune ☐

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: _____

Medical Provider: _____ Phone: ( ) _____

Address: _____

License Number
OR
Official Stamp of Medical Provider

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