



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; <https://www.fdu.edu/campuses/off-campus-sites/> only need to submit the *Off-Site Student Immunization Record*. **If you are taking classes on the Metropolitan or Florham Campus and are not dorming in the Residence Halls do you classify as an Off-Site student.** Instead, 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.



Student Health Services
Metropolitan Campus

Commuter Student Immunization Record

Rev.10 v4 4.3.2020

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 any blood titers)

MMR	#1 _____	#2 _____	OR	TITERS	
NOTE: MEASLES HAS TO BE LIVE, AFTER 1 ST BIRTHDAY				TITER REPORTS MUST BE ATTACHED	
Measles	#1 _____	#2 _____		Date _____	<input type="checkbox"/> Immune Non-immune <input type="checkbox"/>
Mumps	#1 _____	#2 _____		Date _____	<input type="checkbox"/> Immune Non-immune <input type="checkbox"/>
Rubella	#1 _____	#2 _____		Date _____	<input type="checkbox"/> Immune Non-immune <input type="checkbox"/>
Hepatitis B	#1 _____	OR		TITERS	
	#2 _____	#3 _____		Date _____	<input type="checkbox"/> Immune Non-immune <input type="checkbox"/>

2. MENINGOCOCCAL QUADRIVALENT VACCINE

MENINGOCOCCAL (MENINGITIS) INFORMATION IS AVAILABLE AT:

<http://www.cdc.gov/meningitis> and
https://www.nj.gov/health/cd/documents/topics/meningo/meningo_requirements_highered.pdf

By signing below I attest to have read and understood the information on the CDC and New Jersey Department of Health website. Any further questions and/or concerns will be clarified by my HealthCare Provider listed below.

I have *received the meningitis vaccine on: _____ - _____ - _____

*If your initial dose was administered before your 16th birthday, you will be required a booster dose.

STUDENT SIGNATURE: _____ **DATE:** _____

3. TUBERCULOSIS TEST (Must be within one year of starting at FDU, regardless of a BCG vaccine)

Mantoux/PPD Test

Date Given _____ Date Read _____ Result: Negative *Positive Size _____ mm (*induration*)

OR

QuantiFERON-TB Gold or T-Spot Test

Date _____ Result _____ (LAB REPORT MUST BE ATTACHED)

***If Mantoux/PPD Test, QuantiFERON Gold or T-Spot Test is Positive, a Chest X-ray (within 5 years) is required.
Radiologist's report MUST be attached to this form.**

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

**Proof of Immunity is required prior to entrance at the University
You will be placed on medical hold until all the above requirements are met.**

Physical Examination
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TO BE COMPLETED BY A HEALTH CARE PROVIDER

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

Medical History

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Rev. 9 v.3.23.2020

To be completed by the student.

Name: _____			Male <input type="checkbox"/>	Female <input type="checkbox"/>
<i>Last</i>	<i>First</i>	<i>Middle</i>		
Student ID: _____		Date of Birth: <u> </u> / <u> </u> / <u> </u>		

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental/Emotional Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased (age)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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/concussion			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 provide 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		

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.

Student Signature: _____ Date: _____



Student Profile

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Information used solely to provide necessary health care.

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: _____ Citizenship: _____
m m y y y y

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 (Dorm) Commuter (If commuter, provide the address where you will reside)

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

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 by: July 15th for Fall semester, December 15st for Spring, March 15th for Summer