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.*

FDU Student Health Services Metropolitan Campus

All Nursing Students Immunization Record

Rev.7 4.3.2020

NOT CONFIDENTIAL

Immunization records are not confidential as required by law.

Name: ____ Female ☐ Male ☐

Last First Middle

Student ID#: ______________________ Date of Birth: mm dd yyyy ☐ UNDERGRAD ☐ MSN/APN

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 ________ **AND** **MMR Titers**

NOTE: MEASLES HAS TO BE LIVE, AFTER 1ST 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*: ________ **AND** **Varicella Titers**

OR Vaccine #1 ________ #2 ________ Date ________ Immune ☐ Non-immune ☐

Hepatitis B #1 ________ #2 ________ #3 ________ **AND** **Hepatitis B Titers**

HepBsAg Date ________ Positive ☐ Negative ☐

HepBcore IgM Ab Date ________ Positive ☐ Negative ☐

HepBsAb Date ________ Immune ☐ Non-immune ☐

Adult Tdap Date ________________ (within 10 years)

Influenza Vaccine Date ________________ (due annually)

AVAILABLE EVERY FALL

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. Further questions and/or concerns have been clarified by my HealthCare Provider listed below.

☐ I have **received* the Meningitis Quadrivalent Vaccine on: mm / dd / yyyy

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

STUDENT SIGNATURE: ______________________________ **DATE:** ________________

2. TUBERCULOSIS TEST: NURSING STUDENTS REQUIRE *A TWO STEP PPD*. (*Step 2 must be 1-3 weeks after the first)

Mantoux/PPD Test

Step 1 Date Given ________ Date Read ________ Result: ☐ Negative **Positive ☐ Size______mm *(induration)*

***Step 2** 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)**

****Those with *a history* of positive PPD/Mantoux your Physician must complete:** https://www.fdu.edu/wp-content/uploads/2019/11/3862.pdf

Your chest x-ray report must be attached to this form.

Signature of Medical Provider: ______________________ Date: ____________

Medical Provider: ______________________ Phone: ( ) ____________

Address: ____

License Number OR Official Stamp of Medical Provider

Proof of Immunity is required prior to entrance to the University and Clinical sites

You will be placed on medical hold until the above requirements are met

FDU
Student Health Service
Metropolitan Campus

Physical Examination

Rev.16 v3.23.2020

CONFIDENTIAL
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: ____________

Medical Provider: ______________________ Phone: (   ) ____________

Address: ____

License Number
OR
Official Stamp of Medical Provider

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Student Health Services
Metropolitan Campus

Medical History

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To be completed by the student.

Rev. 9 v.3.23.2020

Name: ____ Male ☐ Female ☐

Last *First* *Middle*

Student ID: ______________________ Date of Birth: MM / DD / YYYY

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/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 Health Services
Metropolitan Campus

Student Profile

Rev. 11 v3.23.2020

CONFIDENTIAL

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: 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 (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