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

Resident Student Immunization Record

Rev.7 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 vaccines to date.

1. REQUIRED IMMUNIZATIONS (Laboratory Report must be submitted for any blood titers)

MMR #1 _____ #2 _____ **OR** **Titers for MMR**

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 _____ **OR** **Titers for Varicella**

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

Hepatitis B #1 _____ **OR** **Titers for Hepatitis B**

#2 _____ #3 _____ Date _____ Immune ☐ Non-immune ☐

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 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**: _____

Tdap (within the last 10 years) Date _____ (TD is not acceptable)

2. TUBERCULOSIS TEST (Must be within 6 months prior to the start date of student's first semester)

Mantoux/PPD Test

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

QuantiFERON-TB Gold or T-Spot Test **OR**

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.**
Radiologists 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 and residing in the dorm.
You will be placed on a medical hold if the above requirements are not met.

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Physical Examination

CONFIDENTIAL
TO BE COMPLETED BY A HEALTH CARE PROVIDER

Rev.16 v3.23.2020

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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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: _____

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Student Profile

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Information used solely to provide necessary health care.

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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