FAIRLEIGH DICKINSON UNIVERSITY
Florham Campus

THE WELLNESS CENTER
FLORHAM CAMPUS
285 MADISON AVENUE - WEO-01
MADISON, NEW JERSEY 07940
Phone: (973) 443-8535
Fax: (973) 443-8174

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.*

FAIRLEIGH DICKINSON UNIVERSITY
Florham Campus

Student Profile

CONFIDENTIAL

Information used solely to provide necessary health care.

v.4.17.2020

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☐ Internationa☐ 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

FAIRLEIGH DICKINSON UNIVERSITY
Florham Campus

Medical History

CONFIDENTIAL
To be completed by the student.

v.4.17.2020

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: _____

FAIRLEIGH DICKINSON UNIVERSITY
Florham Campus

Physical Examination

CONFIDENTIAL
TO BE COMPLETED BY A HEALTH CARE PROVIDER

v. 4.17.2020

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

FAIRLEIGH DICKINSON UNIVERSITY
Florham Campus

Commuter Student Immunization Record

v.4.17.2020

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 1ST BIRTHDAY — **TITER REPORTS MUST BE ATTACHED**

Measles #1 _____ #2 _____ Date _____ ☐ Immune Non-immune ☐

Mumps #1 _____ #2 _____ Date _____ ☐ Immune Non-immune ☐

Rubella #1 _____ #2 _____ Date _____ ☐ Immune Non-immune ☐

Hepatitis B #1 _____ #2 _____ #3 _____ **OR** **TITERS** Date _____ ☐ Immune Non-immune ☐

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: _____m m_-_____d d_-_____v v v v_

*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: _____

Medical Provider: _____Phone:( ) _____

Address: _____

License Number
OR
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.

THE LEADER IN GLOBAL EDUCATION

FAIRLEIGH DICKINSON UNIVERSITY

Meningitis Response

Rev. 2017-5-17

IMPORTANT INFORMATION *(Please Read)*

Name: _____ Male ___ Female ___
Last First Middle

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/C/Y/W-135. Two doses are recommended for all adolescents. The first dose is recommended at 11-12 years of age. Since protection wanes, a booster dose is recommended at age 16 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/C/Y/W-135 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

THE LEADER IN GLOBAL EDUCATION

FAIRLEIGH DICKINSON UNIVERSITY

POSITIVE TB TEST CHECKLIST

Name: _____
Last First FDU Student ID#

Date of Birth: ____/____/____ Phone: ( ) _____
Month Day Year

1. A. Positive Mantoux Test

   Date Implanted: _____ Date Read: _____

   Size of Reaction: _____ (millimeters of Induration)

   B. QuantiFERON TB Gold or T-spot Test: Result_____ (MUST ATTACH LAB REPORT)

2. Symptom Assessment for Pulmonary Tuberculosis (*Check all TB- like symptoms that apply):*

   ☐Productive Cough of Undiagnosed Cause (more than 3 weeks in duration) ☐Fever

   ☐Coughing Up Blood (hemoptysis) ☐Chills

   ☐Unexplained Weight Loss (10 pounds or greater without dieting) ☐Chest Pain

   ☐Night Sweats (regardless of room temperature) ☐Very Easily Tired (fatigability)

   ☐Unexplained Loss of Appetite

   ☐*No TB-Like Symptoms Reported or Observed*

3. Chest X-Ray (*Please attach radiologist's report of chest x-ray)*

   Date: _____

   Result: _____

4. Chemoprophylaxis

   Discussed on Date: _____

   Treatment recommended (*Circle One*): YES or NO

   If yes, record chemoprophylaxis treatment given:

   Name of Drug(s):_____

   Dosage: _____

   Date Initiated _____ Duration_____ Date Completed_____

5. BCG: Yes ☐ (date received_____) No ☐

Signature of Medical Provider: _____ Date: _____

Print Name: _____ Phone Number: _____

Address: _____

_____