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.**

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**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.

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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
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# 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
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# 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
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# Resident 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 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.**

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**

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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: _____

_____

# Meningococcal Vaccine Questionnaire for College Students

New Jersey law requires that new students enrolling in a public or private institution of higher education in New Jersey to have received meningococcal vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP). There are two types of meningococcal vaccines that might be required depending on your age and your risks: the meningococcal conjugate vaccine (MenACWY) that protects against serogroups A, C, W, and Y disease; and the meningococcal serogroup B vaccine (MenB) that protects against serogroup B disease.

**MenACWY** (**Menactra®** and **Menveo®**) vaccine is routinely recommended at ages 11-12 years with a booster dose at 16 years. Adolescents who receive their first dose of MenACWY vaccine on or after their 16th birthday do not need a booster dose. Additional doses may be recommended based on risk. People 19 years of age and older are not routinely recommended to receive the MenACWY vaccine unless they are first-year college students living in residential housing or if another risk factor applies.

**MenB** (**Bexsero®** and **Trumenba®**) vaccine is routinely recommended for people ages 10 years or older with high-risk health conditions. People 16-23 years old (preferably at ages 16-18 years) may also choose to get a MenB vaccine.

**INSTRUCTIONS:** *To assist in determining which meningococcal vaccines may be required for you, review each of the indications in the table below, both by age and by increased risk. Place a checkmark in the box next to each indication that applies to you.*

| **By age indication** | | |
|---|---|---|
| **Age** | **MenACWY Requirement** | **MenB Requirement** |
| ☐ ≤18 years of age, not at increased risk | ✓ Vaccine required | × Vaccine not required* |
| ☐ ≥19 years of age, not at increased risk | × Vaccine not required | × Vaccine not required* |
| **By increased risk indication** | | |
| **Indication** | **MenACWY Requirement** | **MenB Requirement** |
| ☐ First-year college student living in residence hall or military recruit | ✓ Vaccine required | × Vaccine not required* |
| ☐ Complement component deficiency or use of a medication known as a complement inhibitor (e.g., eculizumab) | ✓ Vaccine required | ✓ Vaccine required |
| ☐ No spleen or problem with spleen – including sickle cell disease | ✓ Vaccine required | ✓ Vaccine required |
| ☐ HIV infection | ✓ Vaccine required | × Vaccine not required* |
| ☐ Travel to an area where the disease is common. Check www.cdc.gov/travel for travel-related risk | ✓ Vaccine required | × Vaccine not required* |
| ☐ Work in a laboratory with meningococcal bacteria (*Neisseria meningitidis*) | ✓ Vaccine required | ✓ Vaccine required |
| ☐ Part of an outbreak as declared by public health officials—you will be notified if this applies to you | Vaccine required if outbreak caused by serogroup A, C, W or Y | Vaccine required if outbreak caused by serogroup B |

*Though MenB vaccination is not required, persons 16-23 years old may choose to receive MenB vaccine to provide short-term protection against most strains of MenB disease. Learn more about meningococcal disease and MenB vaccination at: www.cdc.gov/meningococcal.

**Please consult with your healthcare provider if you have questions about the meningococcal vaccines or if you need to receive the vaccines to attend a New Jersey institution of higher education.**

NJ Health
New Jersey Department of Health