



**HEALTH SERVICES**  
 11 RYERSON AVENUE  
 CALDWELL, NJ 07006-6195  
 (973) 618-3319  
 http://www.caldwell.edu

Please check **ALL** that apply:

Adult Undergraduate Student

Graduate Student

\*I am taking 12 or more credits per semester

**Student Health Form PLEASE PRINT**

Please read carefully and complete **ALL** sections. Return form to Health Services at above address.  
**Forms cannot be faxed or scanned.** Incomplete forms will result in a Health Hold on your account and jeopardize registration.

Name: \_\_\_\_\_  
 Last First Maiden Name

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ M ( ) F ( ) Student ID#: \_\_\_\_\_  
 Month Day Year

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Form must be completed and signed below by your health care provider **OR** you may attach acceptable evidence of vaccinations to this form. **ALL information must be in English.** \*\*Additional requirements are needed for **International Students** (see below).

**REQUIRED VACCINATIONS:** (Immunization records are NOT confidential)

**Measles, Mumps, Rubella:** New Jersey State Law requires that all students born 1957 or later provide documentation of two Measles, one Mumps, and one Rubella vaccination given on or after your first birthday, separated by at least 28 days, and after 1968 **OR** copy of laboratory test results proving immunity.

<b>OR</b> → ↓	MMR #1 ____/____/____ Month Day Year	MMR #2 ____/____/____ Month Day Year		
<b>MEASLES:</b> Date: #1 ____/____/____ Date: #2 ____/____/____ Month Day Year Month Day Year	<b>OR</b>	Measles (Rubeola) IgG Antibody test demonstrating immunity. <b>Copy of laboratory report must be attached.</b>		Equivocal results are NOT acceptable.
<b>MUMPS:</b> Date: ____/____/____ Month Day Year	<b>OR</b>	RUBELLA: Date: ____/____/____ Month Day Year	Mumps/ Rubella IgG Antibody tests demonstrating immunity. <b>Copy of laboratory report must be attached.</b>	Equivocal results are NOT acceptable.

**Hepatitis B:** \*New Jersey State Law requires that **ALL** students taking 12 or more credits per semester provide documentation of Hepatitis B vaccine series OR copy of laboratory test results proving immunity.

<b>Hepatitis B Doses:</b> #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ Month Day Year Month Day Year Month Day Year	<b>OR</b>	Hep B Surface AB test demonstrating immunity. <b>Copy of laboratory report must be attached.</b>	Equivocal results are NOT acceptable.
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**\*\*Tuberculosis (PPD) Screening:** A Tuberculosis (Mantoux PPD) Test is required for INTERNATIONAL STUDENTS. The test must be administered within 12 months prior to entering school. *If results are positive, a chest x-ray is mandatory and a copy of the x-ray report must be attached.*

Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_ (must be read 48-72 hrs after test) Results: \_\_\_\_\_ mm  
 Month Day Year Month Day Year

**Health Care Provider's name, address, and signature required by law. WILL NOT BE ACCEPTED WITHOUT SIGNATURE.**

Name & title: \_\_\_\_\_  
 (Please print)

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Dear Student and Parent/Guardian:

The Health Services Department would like to inform you about a serious health hazard facing college students. This is the growing threat of meningitis on college campuses across the country.

Meningitis is a rare but potentially fatal disease with early symptoms that resemble the flu, making diagnosis difficult. The symptoms include high fever, severe headache, stiff neck, confusion, nausea and vomiting, exhaustion and/or a rash. If not treated early, meningitis can lead to severe and permanent disabilities, even death.

Meningococcal bacteria are transmitted through air droplets and by direct contact with infected persons. It occurs most often in late winter and early spring-when most college students are away at school. Cases of meningitis among teens and young adults 15-24 years of age-the age of most college students-have more than doubled since 1991. It is estimated that between 100-125 meningitis cases occur on college campuses each year and as many as 15 students will die from the disease.

While the reason for this rise in college campus outbreaks is not fully understood, studies suggest that college students are more susceptible because they live and work in close proximity to each other in dormitories and classrooms. Life style appears to be a risk factor as well, with exposure to active and passive smoking, alcohol consumption, and bar patronage all increasing the chances of contracting meningitis from an infected individual.

A vaccine is available that protects against four of the five strains of the bacteria that causes meningitis in the United States. These types account for nearly two-thirds of meningitis cases among college students. New Jersey State Law requires any student planning to live in campus housing **must** have a meningitis vaccine prior to moving into housing. In addition, the American College Health Association (ACHA) recommends that all other college students consider vaccination against meningitis to protect them against this serious disease.

In support of this recommendation, you are encouraged to discuss meningitis with your physician and consider vaccination prior to your college entrance.

Sincerely,

Cynthia Lee Striano, R.N.

# Meningitis Survey

**Please complete the survey below and return to Health Services in the enclosed envelope *along with your completed health records*:**

***Please note: STUDENTS RESIDING IN CAMPUS HOUSING must complete #1, all other students must choose between statements 1-4.***

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I acknowledge that I have received and read the information about meningitis and the meningitis vaccine.

Please check one:

1. I have received the meningitis vaccine on \_\_\_\_\_.  
(date)
2. I have decided to receive the meningitis vaccine at a later date. \_\_\_\_\_
3. I have decided not to receive the meningitis vaccine. \_\_\_\_\_
4. I am undecided about whether or not to receive the meningitis vaccine. \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date \_\_\_\_\_  
(Please print)

Signature: \_\_\_\_\_  
(If student is under 18 years of age, parent/guardian signature is required)