



## HEALTH SERVICES

120 BLOOMFIELD AVENUE  
CALDWELL, NJ 07006-6195  
(973) 618-3319

<http://www.caldwell.edu>

### DUE DATE:

Fall Semester: **July 15th**  
Spring Semester: **Dec. 15th**

Dear Incoming Student,

Congratulations on your acceptance to Caldwell University and a warm welcome to the Caldwell University Community.

All full-time students are required to complete and submit the health form to the Health Services Department by the due date. **Forms must be uploaded to the Student Health Services Portal.**

**Log onto Cougar Apps using your Net ID and look for this icon or use:**

**<https://caldwell.medicatconnect.com>**



\*Please note that there are additional requirements for students residing in campus housing which can be found on the health form. Failure to complete this form in its entirety will result in registration and/or campus housing holds.

Acceptable proof of immunizations:

- Immunization page of the Caldwell University Health Form completed and signed by your licensed health care professional
- Official school immunization records
- Public Health Department record

If you are unable to obtain proof of past immunization, you must be either revaccinated or provide a laboratory report showing immunity. Immunization and testing for immunity are available through your personal health care provider.

Limited exemptions are allowed for religious and medical reasons. Requests for exemptions must follow specific guidelines which can be obtained from Health Services. Medical exemptions are granted following the completion of the medical exemption form which can be requested from Health Services and completed by your physician. It is important to know that in the case of an outbreak of a communicable disease on campus, students who have been approved for exemptions will not be allowed to remain on campus or attend classes until it is deemed safe by the Department of Health.

Please note that health information provided to this office is confidential and will not be released without written permission or pursuant to government regulation. Immunization records must be made available upon request to state inspectors in order to comply with New Jersey law.

If you have any further questions regarding your health form, please contact Health Services at 973.618.3319.

We wish you health, happiness, and success as you pursue your academic goals.

Health Services Staff



**DUE DATE:**  
Fall Semester Entry **July 15<sup>th</sup>**  
Spring Semester Entry **Dec. 15<sup>th</sup>**

**Please Check:**  
 I will be residing in campus housing  
 I will be commuting

**HEALTH FORM**  
**Traditional Undergraduate**  
**Full-Time Student**

Please read carefully and complete **ALL** sections. Upload form and any supporting documentation to the Student Health Services Portal by due date. Incomplete forms will jeopardize admittance to class and residence halls.

PLEASE PRINT

Name: \_\_\_\_\_  
Last First Middle

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

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

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

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

**IN CASE OF AN EMERGENCY PLEASE NOTIFY THE FOLLOWING :**  
**Primary Contact: (next of kin)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Evening Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**Secondary Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Evening Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**CONSENT/ AUTHORIZATION:**

My signature below indicates that: I consent to medical treatment by the Caldwell University Health Services Staff. I authorize Caldwell University, its employees, agents, or representatives, to take whatever action it/they consider to be warranted regarding my health and safety, and I release Caldwell University for any and all liability for such action. If I require services, prescriptions, or referrals beyond the primary care services available at Caldwell University Health Services, I shall assume full financial responsibility for those services. I consent to the administration of emergency medical treatment, and understand I am financially responsible for any treatment received from off-campus healthcare providers on my behalf in emergency situations. I authorize Caldwell University, its employees, agents, or representatives to contact the individual listed as my Emergency Contact in case of an emergency or in the event that Caldwell University determines such contact is in my best interest.

\_\_\_\_\_  
Signature of Student Date

\_\_\_\_\_  
Signature of Parent/Guardian (if student is under 18) Date

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

<b>MEDICAL HISTORY (to be completed by student)</b>					
<b>EYE</b>			<b>URINARY</b>		
Corrective Lenses/Contacts	No	Yes	Kidney Stones	No	Yes
Other Visual Problems	No	Yes	Urinary Tract Infection	No	Yes
<b>ENT (Ear, Nose, and Throat)</b>			<b>MUSCULOSKELETAL</b>		
Hearing Impairment	No	Yes	Back Problems	No	Yes
Recurrent Throat Infections	No	Yes	Disease or Injury of Joints	No	Yes
<b>CARDIOVASCULAR</b>			<b>HEMATOLOGICAL/ONCOLOGICAL</b>		
High Blood Pressure	No	Yes	Anemia	No	Yes
Palpitations	No	Yes	Cancer	No	Yes
Heart Murmur	No	Yes	Sickle Cell Disease	No	Yes
Fainting	No	Yes	Abnormal Bleeding/Bruising	No	Yes
<b>RESPIRATORY</b>			<b>GASTROINTESTINAL</b>		
Shortness of Breath	No	Yes	Irritable Bowel Syndrome	No	Yes
Asthma	No	Yes	Surgeries	No	Yes
Bronchitis	No	Yes	Constipation	No	Yes
Tobacco Use	No	Yes	Diarrhea	No	Yes
Prior COVID-19 Infection (confirmed by a laboratory test)	No	Yes			
<b>NEUROLOGICAL</b>			<b>REPRODUCTIVE SYSTEM</b>		
Head Injury/Concussion	No	Yes	<b>Women:</b>		
Date of Injury/Concussion: _____			Irregular Periods	No	Yes
Seizures	No	Yes	Severe Cramps	No	Yes
Headaches	No	Yes	Ovarian Cyst	No	Yes
Fainting	No	Yes	History of Sexually Transmitted Disease	No	Yes
Dizziness	No	Yes	<b>Men:</b>		
			Swelling of Scrotum/Testicles	No	Yes
			History of Sexually Transmitted Disease	No	Yes
<b>ENDOCRINE</b>			<b>HEALTH AND NUTRITION</b>		
Diabetes	No	Yes	Do you follow a special diet?	No	Yes
Thyroid	No	Yes	Do you have an eating disorder?	No	Yes
<b>MENTAL HEALTH</b>			<b>DRUG AND ALCOHOL USEAGE</b>		
Depression	No	Yes	Have you ever felt you should cut down on your drinking?		
Anxiety	No	Yes	No Yes		
Previous psychological counseling	No	Yes	Have people annoyed you by criticizing your drinking?		
Current psychological counseling	No	Yes	No Yes		
History of Suicide Ideation	No	Yes	Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover?		
History of Suicide Attempts	No	Yes	No Yes		
Psychotropic medications and dose (please list): _____ _____ _____			Have you ever used any of the following substances? (please circle all that apply): marijuana, prescription medications for recreational use, ecstasy, molly, bath salts, heroin, cocaine OTHER		
<b>FAMILY HISTORY-Circle all that apply</b>					
<b>FATHER</b> Living/Deceased			<b>MOTHER</b> Living/Deceased		
High Blood Pressure	Heart Disease		High Blood Pressure	Heart Disease	
Cancer	Diabetes	Thyroid Disease	Cancer	Diabetes	Thyroid Disease



<b>Student's Name:</b> _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>(Last)</span> <span>(First)</span> </div>	<b>Birth Date:</b> ____/____/____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>M</span> <span>D</span> <span>Y</span> </div>
<b>Caldwell ID:</b> _____	<b>Starting Term:</b> Fall _____ Spring _____ Year _____
<b>Cell Phone #:</b> _____	<b>I am a full time students (12 or more credits):</b> Yes _____ No _____
<b>I will reside in on-campus housing:</b> Yes _____ No _____	<b>I am an International Student:</b> Yes _____ No _____

**REQUIRED IMMUNIZATIONS:**

**Measles, Mumps and Rubella:** New Jersey State Law requires that ALL students provide documentation of two Measles, one Mumps and one Rubella vaccination OR copy of laboratory test results proving immunity.

<b>MMR (two dose series):</b>  Dose #1 ____/____/____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>M</span> <span>D</span> <span>Y</span> </div> Dose #2 ____/____/____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>M</span> <span>D</span> <span>Y</span> </div>	OR	<b>Measles:</b> Dose #1 ____/____/____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>M</span> <span>D</span> <span>Y</span> </div> <b>Measles:</b> Dose #2 ____/____/____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>M</span> <span>D</span> <span>Y</span> </div> <b>Mumps:</b> Dose #1 ____/____/____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>M</span> <span>D</span> <span>Y</span> </div> <b>Rubella:</b> Dose #1 ____/____/____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>M</span> <span>D</span> <span>Y</span> </div>	OR	<b>MMR Antibodies, IgG</b> may be submitted to prove immunity.  <b>A copy of the laboratory report must be attached</b>  <b>Equivocal results are NOT accepted</b>
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**Hepatitis B:** New Jersey State Law requires that ALL students (registered for 12 credits or more) provide documentation of Hepatitis B vaccine OR copy of laboratory test results proving immunity.

<b>Hepatitis B (three dose series):</b>  Dose #1 ____/____/____    Dose #2 ____/____/____    Dose #3 ____/____/____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>M</span> <span>D</span> <span>Y</span> <span>M</span> <span>D</span> <span>Y</span> <span>M</span> <span>D</span> <span>Y</span> </div>	OR	<b>Hepatitis B Surface Antibody</b> test demonstrating immunity. <b>Copy of laboratory report must be attached</b> <b>Equivocal results are NOT accepted</b>
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**Tuberculosis Testing:**

**US Residents: Required for students entering on-campus housing.** Testing can be either an IGRA or a PPD  
**ALL International Students (resident on campus or commuter): Testing must be an IGRA Lab test** (TB skin testing will not be accepted for international students.)  
 TB testing must have been performed **within 6 months** prior to entering campus housing or the start of the semester for commuters. If an IGRA is performed a copy of the lab report must be attached to this form. If TB testing is positive, a chest x-ray is mandatory and a copy of the x-ray report (dated after the positive test result) must be attached.

PPD Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_    PPD Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_ (must be read 48-72 hours after test)    PPD Result: \_\_\_\_\_ mm  

M
D
Y
M
D
Y

 IGRA Test performed: \_\_\_\_\_    Date of Lab Test \_\_\_\_/\_\_\_\_/\_\_\_\_    Attach lab report   

M
D
Y

**Strongly Recommended Immunizations:**

**Diphtheria/Tetanus within the last 10 years:** Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  

M
D
Y

**Tetanus, Diphtheria, Pertussis (T-Dap):** Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  

M
D
Y

**Varicella (Chickenpox):** Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_    Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  

M
D
Y
M
D
Y

**Health Care Professionals Signature:** \_\_\_\_\_ **Date and Office Stamp Required**

## **MENINGITIS INFORMATION**

**After reading this information, please complete the meningitis immunization form including your acknowledgement signature and vaccine information.**

New Jersey State law requires that colleges provide incoming students and their parents with information about meningitis infection and available vaccinations. This information provides the most up to date scientific evidence regarding this devastating disease.

### **The Disease**

Meningococcal meningitis is a bacterial infection that can have sudden onset and strike otherwise healthy people, it can cause permanent disability and death. Although it is rare, teens and young adults age 16-23 are at increased risk. College students who live and work in close proximity to each other are at particularly high risk. The infection can attack the lining of the brain, spinal cord and the bloodstream and cause flu like symptoms, which can make diagnosis difficult. Common symptoms are: confusion, fatigue, rash of dark purple spots, sensitivity to light, stiff neck, nausea, vomiting, headache and high fever. The rates of meningococcal disease have been declining in recent years in part to consistent vaccination. Even with the decline in cases, meningococcal meningitis continues to have a fatality rate of 10-15% so continued protection is necessary to prevent disease.

### **Prevention**

The best way to protect yourself is to get vaccinated. Currently two different types of meningitis vaccines are available. The first vaccine protects against four strains of meningococcal bacteria known as A,C,Y,W-135 (Menactra® and Menveo®). The Advisory Committee of Immunization Practices (ACIP) recommends two doses for all adolescents. The first dose is typically given at 11 or 12 years old. Because the vaccine wanes in effectiveness a booster is recommended at age 16 so the adolescent has continued protection when they are at highest risk. This vaccine is mandatory for all students under the age of 19 at the start of the student's first semester **AND** everyone (regardless of age) living in University housing (see page 6 for more information about requirements).

A second vaccine protects against Meningitis type B. This vaccine is not mandatory for most students, however there have been outbreaks and individual cases of meningitis type B on college campuses in recent years. Teens and young adults **may** be vaccinated with the serogroup B vaccine (Bexsero® or Trumenba®). In June of 2015 the ACIP recommended that given the seriousness of meningococcal disease and the availability of a licensed vaccine, individuals are encouraged to consult with their healthcare provider regarding administration of this vaccine. Please refer to the guidelines on page 6 to determine if you are required to have a Meningitis B vaccine series.

If you have more questions regarding vaccine requirements please call Health Services at 973.618.3319. You can also visit the Center for Disease Control website at <https://www.cdc.gov/meningococcal/> or American College Health Association website at <https://www.acha.org/>.

**MENINGITIS RESPONSE FORM: MENINGOCOCCAL VACCINE REQUIREMENTS**

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 of Immunization Practices (ACIP). There are two types of meningococcal vaccines that might be required based on your age and your risks: the meningococcal conjugate vaccine (MenACYW) that protects against serogroups A, C, Y and W disease; and the meningococcal serogroup B vaccine (MenB) that protects against serogroup B disease.

**MenACYW (Menactra® and Menveo®)** vaccine is routinely recommended at ages 11-12 years with a booster at 16 years. Adolescents who receive their first dose of MenACYW vaccine on or after their 16<sup>th</sup> 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 required to receive the MenACYW vaccine unless they are 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) may also choose to get a MenB vaccine.

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

**ALL TRADITIONAL FULL-TIME UNDERGRADUATE STUDENTS:**

<b>Student Name:</b>	<b>Student ID Number:</b>
<b>Student Signature:</b>	<b>Parent Signature (if under 18):</b>

**Please check the applicable boxes below:**

<b>Age:</b>	<b>MenACYW Requirement</b>	<b>MenB requirement</b>
<input type="checkbox"/> ≤ 18 years of age, not at increased risk (see below)	√ Vaccine required (administered after age 16)	Vaccine not required (but recommended)
<input type="checkbox"/> ≥ 19 years of age, not at increased risk (see below)	X Vaccine not required	X Vaccine not required
<b>Increased Risk:</b>	<b>MenACYW Requirement</b>	<b>MenB requirement</b>
<input type="checkbox"/> Students living in on-campus housing (Must be administered after age 16 and within 5 years of entering campus housing)	√ Vaccine required (administered after age 16)	X Vaccine not required
<input type="checkbox"/> Complement component deficiency or use of medication known as complement inhibitor (e.g. eculizumab)	√ Vaccine required	√ Vaccine required
<input type="checkbox"/> No spleen, or problem with spleen- including sickle cell disease	√ Vaccine required	√ Vaccine required
<input type="checkbox"/> HIV infection	√ Vaccine required	X Vaccine not required
<input type="checkbox"/> Work in a laboratory with meningococcal bacteria (Neisseria meningitis)	√ Vaccine required	√ Vaccine required

**Please enter vaccination dates as applicable:**

<p><b>Meningococcal vaccine A,C,Y,W-135:</b> Dose #1 (at age 11-12 yr) ___/___/___ Dose #2 (after age 16) ___/___/___</p> <p style="text-align: center;">M D Y M D Y</p>
<p><b>Meningococcal B:</b> Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___</p> <p style="text-align: center;">M D Y M D Y M D Y</p> <p>Which one: <input type="checkbox"/> Bexsero® <input type="checkbox"/> Trumenba®</p>

**This form is NOT VALID unless completed, signed, and dated by a healthcare professional.**

<p><b>Healthcare Provider Information: REQUIRED</b></p> <p><b>Name :</b> _____</p> <p><b>Signature:</b> _____</p> <p><b>Date:</b> _____</p>	<p><b>Health Care Provider's Stamp: REQUIRED</b></p>
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