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

DUE DATE:
Fall Semester: **July 15**
Spring Semester: **December 15**

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 return the **original** health form to the Health Services Department by the due date. *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. **Forms cannot be faxed.**

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 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 be submitted in detailed writing. Medical exemptions must be signed by your health care provider. Students submitting religious or medical exemptions must provide this office with documentation of any previously administered immunizations. It is important to know that in the case of an outbreak of a communicable disease on campus, students who have submitted 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 are not confidential because your immunization status must be made available to state inspectors and select University officials 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

CALDWELL UNIVERSITY™

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Health Services _____

PHYSICAL EXAMINATION FORM

Adult Student Residing in Campus Housing

Please check:
☐ **Adult Undergraduate**
☐ **Graduate**

DUE DATE:
Fall Semester Entry **July 15**
Spring Semester Entry **December 15**

Please read carefully and complete **ALL** sections. Return form to Health Services at above address by due date. Incomplete forms will be returned to applicant and will jeopardize admittance to class and the residence halls.

STUDENT SECTION

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 OR EMERGENCY TRANSPORT TO A HOSPITAL, PLEASE CONTACT:

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:

In case of illness or injury, permission is granted to treat the student named at Caldwell University Health Services. In the event that I am unable to consent at the time due to injury or illness, I consent to the administration of emergency medical treatment at the student's expense. I authorize Caldwell University, its employees, agents, or representatives, to take whatever actions it/they consider to be warranted regarding my health and safety, and I release Caldwell University from any and all liability for such action. I authorize Caldwell University, its employees, agents, or representatives to contact the individual listed as my Emergency Contact in case of emergency or in the event that Caldwell University determines such contact is in my best interest.

_____
Signature of Student Date

Name: _____
Last First

MEDICAL HISTORY (to be completed by student)

EYE

Corrective Lenses/Contacts	No	Yes
Other Visual Problems	No	Yes

ENT (Ear, Nose, and Throat)

Hearing Impairment	No	Yes
Recurrent Throat Infections	No	Yes

CARDIOVASCULAR

High Blood Pressure	No	Yes
Palpitations	No	Yes
Heart Murmur	No	Yes
Fainting	No	Yes

RESPIRATORY

Shortness of Breath	No	Yes
Asthma	No	Yes
Bronchitis	No	Yes
Tobacco Use	No	Yes

NEUROLOGICAL

Head Injury/Concussion	No	Yes
Date of injury/concussion: _____		
Seizures	No	Yes
Headaches	No	Yes
Fainting	No	Yes
Dizziness	No	Yes

ENDOCRINE

Diabetes	No	Yes
Thyroid	No	Yes

MENTAL HEALTH

Depression	No	Yes
Anxiety	No	Yes
Previous psychological counseling	No	Yes
Current psychological counseling	No	Yes
History of Suicide Ideation	No	Yes
History of Suicide Attempts	No	Yes

Psychotropic medications and dose (please list):
_____
_____
_____
_____

URINARY

Kidney Stones	No	Yes
Urinary Tract Infection	No	Yes

MUSCULOSKELETAL

Back Problems	No	Yes
Disease or Injury of Joints	No	Yes

HEMATOLOGICAL/ONCOLOGICAL

Anemia	No	Yes
Cancer	No	Yes
Sickle Cell Disease	No	Yes
Abnormal Bleeding/Bruising	No	Yes

GASTROINTESTINAL

Irritable Bowel Syndrome	No	Yes
Surgeries	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes

REPRODUCTIVE SYSTEM

Women:		
Irregular Periods	No	Yes
Severe Cramps	No	Yes
Ovarian Cyst	No	Yes
History of Sexually Transmitted Disease	No	Yes
Men:		
Swelling of Scrotum/Testicles	No	Yes
History of Sexually Transmitted Disease	No	Yes

HEALTH AND NUTRITION

Do you follow a special diet?	No	Yes
Do you have an eating disorder?	No	Yes

DRUG AND ALCOHOL USAGE

Have you ever felt you should cut down on your drinking? No Yes

Have people annoyed you by criticizing your drinking? No Yes

Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover? No Yes

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)

FAMILY HISTORY- Circle all that apply

Mother Living/Deceased
High Blood Pressure Heart Disease
Cancer Diabetes Thyroid Disease

Father Living/Deceased
High Blood Pressure Heart Disease
Cancer Diabetes Thyroid Disease

Name: _____
Last First

Caldwell University Health Services

PHYSICAL *(Must be completed within 12 months of entrance by a physician)*

**BP / **	**P R**	Height		Weight	

PHYSICAL EXAM:		
Eyes	WNL	Remarks:
Ears	WNL	Remarks:
Nose	WNL	Remarks:
Throat	WNL	Remarks:
Neck	WNL	Remarks:
Lungs	WNL	Remarks:
Heart	WNL	Remarks:
Abdomen	WNL	Remarks
Lymph glands	WNL	Remarks:
G.U.	WNL	Remarks:
Skin	WNL	Remarks:
Neuro	WNL	Remarks:
Musculoskeletal	WNL	Remarks:

Please list ALL current medications: _____

_____

Allergies: _____

_____

Does student have any physical/mental disability which should **limit** participation.. YES / NO (Check those that apply)

□ Campus Residency □ Classroom Activities □ Competitive Sports

If yes, please explain: _____

_____

Has student received treatment or counseling for a psychiatric condition, personality disorder or emotional problem? YES / NO

If yes, please explain: _____

_____

Physician's Name (please print) _____

Address _____

Phone# _____Fax#_____

Physician's Signature _____ Date of completed exam_____

Caldwell University Health Services, 120 Bloomfield Ave., Caldwell, N.J., 07006, Phone: 973-618-3319

IMMUNIZATION RECORD
(Immunization records are NOT confidential)

Name:_____
Last First Middle

Birth Date:_____/_____/_____
Month Day Year

Your health care provider must complete this page, provide any supporting documentation and SIGN below, OR you may attach acceptable evidence of vaccination to the form. ALL information must be in English.

REQUIRED VACCINATIONS:

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

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

Hepatitis B: New Jersey State Law requires that ALL students provide documentation of Hepatitis B vaccine OR copy of laboratory test results proving immunity.

Hepatitis B Doses: **#1**_____/_____/_____ Month Day Year **#2**_____/_____/_____ Month Day Year **#3**_____/_____/_____ Month Day Year	**OR**	Hep B Surface Antibody test demonstrating immunity. **Copy of laboratory report must be attached.**	Equivocal results are NOT acceptable.

Meningitis: Students will NOT be permitted entry to campus housing without proof of Meningitis vaccination. Vaccination must include Groups A, C, Y, W-135. ***Vaccine must have been administered after age of 16 and within five (5) years of entering campus housing.***

. **MCV4 (i.e. Menactra, Menveo, Mencevax)** Date: _____/_____/_____ Month Day Year
\

Tuberculosis (PPD) Screening: A Tuberculosis Skin Test is required for ALL students ENTERING CAMPUS HOUSING **and** ALL INTERNATIONAL STUDENTS (on campus residents and commuters). The test must have been administered within 12 months prior to entering housing. If positive , a chest x-ray is mandatory and a copy of the x-ray report must be attached.

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

STRONGLY RECOMMENDED VACCINATIONS:

Diphtheria-Tetanus within the last 10 years: Date:____/____/____ Month Day Year **or Tetanus, Diphtheria, Pertussis (T dap):** Date:____/____/____ Month Day Year

Varicella (Chickenpox): Dose #1 ____/_____/_____ Month Day Year Dose #2 ____/_____/_____ 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:_____

Signature:_____ _____

Date:_____ Phone: (_____)_____

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Dear Student:

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. It is important to note that if you will be residing in campus housing, you must submit proof of a meningitis vaccine according to the guidelines on the immunization page of the health form.

Sincerely,
Cynthia Striano, M.S.N., R.N.
Director of Health Services

CALDWELL UNIVERSITY

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.

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: _____