



HEALTH SERVICES

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

<http://www.caldwell.edu>

Dear Adult Undergraduate/Graduate Student,

The Health Services Department welcomes you to the Caldwell University Community.

New Jersey State Law mandates immunization requirements for college students. You must complete and return the health form to the Health Services Department by the due date. **Forms cannot be faxed.** *Please note that there may be additional requirements for graduate counseling and nursing students prior to starting your practicum/clinical rotations. More information is available by calling Health Services. Failure to complete this form in its entirety will result in a registration hold.

Acceptable proof of immunizations:

- 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 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.

Students born before January 1, 1957 are exempt from the Measles, Mumps, and Rubella requirement, however, **must comply with the Hepatitis B requirement** if taking 12 or more credits per semester.

Health information that you provide to Health Services will be treated as confidential and will not be released without your written permission or pursuant to government authorization. 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 the 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

Name: _____
Last
First

MEDICAL HISTORY (to be completed by student)					
EYE			URINARY		
Corrective Lenses/Contacts	No	Yes	Kidney Stones	No	Yes
Other Visual Problems	No	Yes	Urinary Tract Infection	No	Yes
ENT (Ear, Nose, and Throat)			MUSCULOSKELETAL		
Hearing Impairment	No	Yes	Back Problems	No	Yes
Recurrent Throat Infections	No	Yes	Disease or Injury of Joints	No	Yes
CARDIOVASCULAR			HEMATOLOGICAL/ONCOLOGICAL		
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
RESPIRATORY			GASTROINTESTINAL		
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
NEUROLOGICAL			REPRODUCTIVE SYSTEM		
Head Injury/Concussion	No	Yes	Women:		
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	Men:		
			Swelling of Scrotum/Testicles	No	Yes
			History of Sexually Transmitted Disease	No	Yes
ENDOCRINE			HEALTH AND NUTRITION		
Diabetes	No	Yes	Do you follow a special diet?	No	Yes
Thyroid	No	Yes	Do you have an eating disorder?	No	Yes
MENTAL HEALTH			DRUG AND ALCOHOL USAGE		
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)		
FAMILY HISTORY- Circle all that apply					
Mother Living/Deceased			Father Living/Deceased		
High Blood Pressure Heart Disease			High Blood Pressure Heart Disease		
Cancer Diabetes Thyroid Disease			Cancer Diabetes Thyroid Disease		

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 _____ <small>Month Day Year</small>	MMR #2 _____ <small>Month Day Year</small>
MEASLES:		OR	Measles (Rubeola) IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
Date: #1 _____ <small>Month Day Year</small> Date: #2 _____ <small>Month Day Year</small>			
MUMPS:		OR	Mumps/ Rubella IgG Antibody tests demonstrating immunity. Copy of laboratory report must be attached.
Date: _____ <small>Month Day Year</small> RUBELLA: Date: _____ <small>Month Day Year</small>			

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

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 (Tdap):** 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: (_____) _____



Health Services
120 Bloomfield Avenue
Caldwell, NJ 07006
973 618 3319

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. The American College Health Association (ACHA) recommends that all 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, M.S.N., R.N.
Director of Health Services



Meningitis Survey

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

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: _____