



## 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 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.

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



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

<b>MEDICAL HISTORY</b> (to be completed by student)					
<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
<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 USAGE</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>Mother</b> Living/Deceased			<b>Father</b> Living/Deceased		
High Blood Pressure    Heart Disease			High Blood Pressure    Heart Disease		
Cancer    Diabetes    Thyroid Disease			Cancer    Diabetes    Thyroid Disease		

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

**Caldwell University Health Services**

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

<b>BP</b> /	<b>P</b>	<b>R</b>	Height		Weight	
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<b>PHYSICAL EXAM:</b>		
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 \_\_\_\_\_

**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.

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

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

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

**STRONGLY RECOMMENDED VACCINATIONS:**

**Diphtheria-Tetanus within the last 10 years:** Date: \_\_\_\_\_ **or Tetanus, Diphtheria, Pertussis (Tdap):** Date: \_\_\_\_\_  
Month Day Year Month Day Year

**Varicella (Chickenpox):** Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_  
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: \_\_\_\_\_ Address: \_\_\_\_\_  
(Please print)

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

Date: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_



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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. 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



## 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)