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

DUE DATE:
July 1st

Dear Incoming 2nd Degree Nursing 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 and/or clinical clearance 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 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

CALDWELL UNIVERSITY

2ND DEGREE NURSING STUDENTS

HEALTH REQUIREMENTS AND CLINICAL PRACTICE CLEARANCE

All undergraduate nursing students entering clinical courses are required to have health records. The purpose of this health requirement and clinical practice clearance is to protect students as well as the patients with whom they will be working. It is also important to determine that the student is able to fulfill the objectives of the educational programs.

Clinical clearance also requires students to complete and submit the following requirements:

- By **July 1, 2021**, all completed health forms should 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

- Or by mail to:

  Caldwell University
  Health Services
  120 Bloomfield Avenue, Caldwell, NJ 07006
  Telephone # 973-618-3319

- Forms cannot be emailed or faxed

  For questions related to health forms call Health Services at 973-618-3319

- Annual Flu vaccination will be administered by Caldwell University Health Services in the early fall at no cost.

Students are to make 1 copy of all documents submitted, and are expected to have it available when on the clinical site ready for review if asked to produce documents by the nursing leadership.

STUDENTS WILL NOT BE PERMITED TO BEGIN THEIR CLINICAL PRACTICUM IF THESE MATERIALS ARE NOT SUBMITTED

NOTE: Students are responsible for ensuring that all documentation remains up to date throughout each of their clinical placements, specifically any change in health status must be immediately reported to Cindy Striano, Executive Director, Health Services, 973-618-3319, cstriano@caldwell.edu

CALDWELL UNIVERSITY

DUE DATE:
July 1st

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

HEALTH FORM
Second Degree Nursing 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 clinicals 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

MEDICAL HISTORY (to be completed by student) MUST BE SIGNED BY PHYSICIAN

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
Prior COVID-19 Infection (confirmed by a laboratory test) 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 USEAGE
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

FATHER Living/Deceased			**MOTHER** Living/Deceased		
High Blood Pressure		Heart Disease	High Blood Pressure		Heart Disease
Cancer	Diabetes	Thyroid Disease	Cancer	Diabetes	Thyroid Disease

_____ _____
Student signature **Date** **Physician' signature (Office stamp required)** **Date**

Name:_____
Last First

PHYSICAL: (Must have been performed by a physician within 6 months of the start of clinicals.) All Sections Must be Fully Completed.

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 the student have any physical/mental disability which should **limit** participation? YES/NO (Check those that apply)
☐ Clinical Activities ☐ Campus Residency ☐ Classroom Activities ☐ Competitive Sports
If yes, please explain _____
_____

Has the 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)_____
License #_____
Address _____
Phone# _____ Fax# _____

Physician's Signature:_____ **Date of completed exam:**_____

Office Stamp Required:

Student's Name: _____ **(Last) (First)**	**Birth Date: _____/_____/_____** M D Y
Caldwell ID:	**Starting Term: Fall_____ Year_____**
Cell Phone #:	**I am a full time students (12 or more credits): Yes_____No_____**
I will reside in on-campus housing: Yes___No____	**I am an International Student: 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.

MMR (two dose series): Dose #1 _____/_____/_____ M D Y Dose #2 _____/_____/_____ M D Y	**OR**	**Measles:** Dose #1 _____/_____/_____ M D Y **Measles:** Dose #2 _____/_____/_____ M D Y **Mumps:** Dose #1 _____/_____/_____ M D Y **Rubella:** Dose #1 _____/_____/_____ M D Y	**OR**	**MMR Antibodies, IgG may be submitted to prove immunity.** **A copy of the laboratory report must be attached** **Equivocal results are NOT accepted**

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.

Hepatitis B (three dose series): Dose #1 _____/_____/_____ M D Y Dose #2 _____/_____/_____ M D Y Dose #3 _____/_____/_____ M D Y	**OR**	**Hepatitis B Surface Antibody test demonstrating immunity.** **Copy of laboratory report must be attached** **Equivocal results are NOT accepted**

Healthcare Provider Information REQUIRED **Name:_____** **Signature:_____** **Date:_____**	**Healthcare Provider's Stamp REQUIRED**

SUPPLEMENTAL NURSING HEALTH REQUIREMENTS: Must be completed for all Nursing Students

Student's Name:_____ **Birth Date**:____/_____/_____
(Last) (First) M D Y

1. **Rubeola, Rubella, and Mumps titers documenting immunity:**
-Copies of lab reporter with titer results must be attached. Equivocal results are NOT acceptable.
-If titers are negative or equivocal, additional vaccination and post vaccine titer is required.
-Additional vaccination: Date _____

2. **Varicella titer documenting immunity:**
-Documentation of 2 doses of Varicella vaccine given at least 28 days apart:
Date # 1 _____ Date # 2 _____
-Copies of lab report with titer results must be attached. Equivocal results are NOT acceptable
-If titers are negative or equivocal, additional vaccination and post vaccine titer is required.
-Additional vaccination: Date _____

3. **Hepatitis B Surface Antibody test documenting immunity:**
-Copy of lab report, with titer results must be attached. Equivocal results are NOT acceptable.
-If negative or equivocal, the series must be repeated with post vaccine titer
Additional Vaccine: Date # 1 _____ Date # 2 _____ Date # 3 _____

4. **Tdap Vaccine, if 2 more years since the last Td booster or since the primary DPT series:**
Type of vaccine:_____ Date of vaccine: _____

5**. 2-Step Tuberculosis Skin Test (TST) (within 6 months of starting clinical) (TSTs must be given 1-3 weeks apart):**
Documentation must include date given, date read with reading in millimeters of induration, regardless of previous BCG vaccination. Reading must be done 48-72 hours after test is given.

1st TST: Date Given _____ Date Read _____ Results _____ mm induration
2nd TST: Date Given _____ Date Read _____ Results _____ mm induration
Students with a positive TST or a history of positive PPD must provide a Chest X-ray report from within the past 6 months. Students will be exempt from a TST only under the following circumstances:

- Documented history of TB disease
- Documentation of adequate treatment for TB disease or latent TB infection (LBTI)
- Documentation of medical contraindication (ulceration of site or anaphylaxis)

6. A history and physical exam within 6 months of starting clinical is required. See Page 3.

7. Urinalysis within 6 months of starting clinical is required (please attach lab report).

Where applicable, all Lab Reports must be attached.
All information must be legible, in English, and signed by the healthcare provider.

Health Care Provider (print name) _____

NJ License # _____

Address _____

Telephone # _____Fax#_____

Signature _____ Date_____

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 16th 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.**

Second Degree Nursing Students
Form is NOT VALID if NOT signed by Student

Student Name:	**Student ID Number:**	
My signature below affirms that I have received and reviewed the meningitis information provided by Caldwell University, I am 19 years or older, *not living on campus*, and I do not meet any of the high risk categories as stated below that would necessitate my being vaccinated against meningitis.		
DOB:	**Signature:**	**Date:**

Age:	**MenACYW Requirement**	**MenB requirement**
☐ ≤ 18 years of age, not at increased risk (see below)	**√ Vaccine required (administered after age 16)**	**Vaccine not required (but recommended)**
☐ ≥ 19 years of age, not at increased risk (see below)	**X Vaccine not required**	**X Vaccine not required**
Increased Risk:	**MenACYW Requirement**	**MenB requirement**
☐ **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**
☐ Complement component deficiency or use of medication known as complement inhibitor (e.g. eculizumab)	**√ Vaccine required**	**√ Vaccine required**
☐ No spleen, or problem with spleen- including sickle cell disease	**√ Vaccine required**	**√ Vaccine required**
☐ HIV infection	**√ Vaccine required**	**X Vaccine not required**
☐ Work in a laboratory with meningococcal bacteria (Neisseria meningitis)	**√ Vaccine required**	**√ Vaccine required**

Form only needs to be signed by a healthcare provider IF vaccination information is required:

Meningococcal vaccine A,C,Y,W-135: Dose #1 (at age 11-12 yr) _____/_____/_____ Dose #2 (after age 16) _____/_____/_____
M D Y M D Y

Meningococcal B: Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
M D Y M D Y M D Y

Which one: ☐ Bexsero® ☐ Trumenba®

Healthcare Provider Information: REQUIRED	**Health Care Provider's Stamp: REQUIRED**
Name :_____ **Signature:**_____ **Date:**_____	

Caldwell University
School of Nursing & Public Health
Student Nurse Essential Functions

Listed below are the Essential Functions of a Student Nurse. Students need to be aware of the Essential Functions prior to attendance. Please read carefully. It is the student's responsibility to notify the University of any disability impacting his or her ability to perform essential functions.

Essential Functions: Performance Requirements

Ability to use senses
Visual acuity with corrective lenses to identify color changes in skin, respiratory movement in patients; read fine print/writing on physicians orders, monitors, equipment calibrations, measure medications in syringes, IV's, etc.

Hearing ability with auditory aids to hear monitor alarms, emergency signals, call bells, telephone orders, to hear blood pressure, heart, lung and abdominal sounds with a stethoscope, to understand a normal speaking voice without viewing the speaker's face.

Motor Ability
Tactile ability to feel differences in skin temperature and to perform physical assessment.
Physical ability to walk long distances, to stand for prolonged periods, to lift, move, and transfer patients/equipment of 20 lbs or more, to maneuver in limited space to perform CPR, to provide routine and emergency care, to have manual dexterity and feeling ability of hands to insert tubes, prepare medications, and perform technical skills.

Ability to Communicate
Ability to communicate effectively in English in verbal and written form through interaction with patients, family, and healthcare members from a variety of social, emotional, cultural, and intellectual back grounds; to write clearly and correctly on patient's record for legal documentation.

Ability to Problem-Solve
Intellectual and conceptual ability to think critically in order to make decisions, which includes measuring, calculating, reasoning, analyzing, prioritizing, and synthesizing data.

Ability to Maintain Emotional Stability
Ability to communicate and perform situation-appropriate nursing care safely under stress and adapt to changing levels of acuity in clinical and patient situations without exhibiting inappropriate or unprofessional behaviors as described below:

> Unsafe performance/behavior: "Behavior that places the client (patient), staff (or peers) in either physical or emotional jeopardy. Physical jeopardy is the risk of causing physical harm. Emotional jeopardy means that the student creates an environment of anxiety or distress which puts the client (patient), (patient's) family, (staff or peers) at risk for emotional or psychological harm. Unsafe practice (performance /behavior) is an occurrence or pattern of behavior involving unacceptable risk "(Scanlan, etal., 2001)
>
> Unethical clinical practice/performance: Violation of the standards

Last name (print) _____First name (print)_____

Birth date_____ Student ID # _____

STUDENT HEALTH CLEARANCE FORM

Health Care Provider to Complete

Does the student have any disease or condition that would limit his or her full participation in the nursing program?

No ☐

By signing below, the health care provider has determined that the named individual is eligible for clinical practice and agrees with the following statement:
After reviewing the Essential Functions listed on page six (6), I find him/her to be in good physical and mental health; he/she is free from any health impairment that is of potential risk to patients, personnel, students, or faculty and which might interfere with the performance of the Essentials Functions as a student nurse with or without a reasonable accommodation.
If a reasonable accommodation is required, I have identified the accommodation and the basis of the accommodation on a separate attachment.

Health Care Provider (print name) _____
NJ License # _____
Address _____
Telephone # _____Fax#_____
Signature _____ Date_____
Office Stamp Required:

----------OR----------

Does the student have any disease or condition that would limit his or her full participation in the nursing program?

Yes ☐

If yes, please document accommodations required on next page.

Health Care Provider (print name)_____
NJ License # _____
Address _____
Telephone # _____Fax#_____
Signature _____ Date _____
Office Stamp Required:

Recommended Accommodations

1. Student (Name)_____ should be excused from clinical rotations/patient care until (date)_____
due to:_____
_____(diagnosis)

2. Based on my assessment and the student's diagnosis
_____
_____
_____

Student should consider a medical leave of absence, for which I understand there will be additional documentation that will need to be completed.

3. Any other accommodations recommended
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Health Care Provider (print name)_____
NJ License # _____
Address _____
Telephone # _____Fax#_____
Signature _____ Date _____
Office Stamp Required: