DUE DATE:
EOF Summer Program **June 1st**
Fall Semester Entry **July 15th**
Spring Semester Entry **Dec. 15th**

CALDWELL UNIVERSITY

Dear Incoming Student,

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

Completed health forms must be submitted by the due date listed above.

Forms must be uploaded to the Health Services Portal.
Log onto Cougar Apps using your Net ID and look for the Health Services Portal 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 for all requirements are:

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

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. 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 from the state mandated vaccinations. 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.

Health information provided to this office is confidential and will not be released without written permission or pursuant to government regulation. Immunization records will 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 or any of the requirements, 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

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

DUE DATE:

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Undergraduate Student Health Form

Please read carefully and complete **ALL** sections. Upload forms and supporting documentation to the Health Services Portal by due date. Incomplete forms will jeopardize registration and clearance for campus housing.

PLEASE PRINT

Name: _____
Last First Middle Birth or Maiden Name

Birthdate: _____/_____/_____ M ( ) F ( ) Age: _____ Student ID# (if known):_____
Month Day Year

Legal Home Permanent Address:_____

City:_____ State:_____ Zip Code:_____ Country:_____

Current Local Address (if NOT living at home or on campus): _____

City: _____State: _____Zip Code: _____

Home Phone: (_____)_____ US Cell Phone (_____)_____

IN CASE OF AN EMERGENCY, PLEASE NOTIFY THE FOLLOWING:
If possible, one of your emergency contacts should reside in the United States.

Primary Contact:

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 Date
(if student is under 18)

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
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

Name:_____
Last First

PHYSICAL: (Must have been performed by a physician within 12 months of the start of the student's first semester) All Sections Must be Fully Completed.
Note: Physical NOT required for commuter students (not living on campus) 25 years or older.

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)
☐ 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)_____

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:	**Cell Phone #:**

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**

Hepatitis B: New Jersey State Law requires that ALL students (registered for 12 credits or more) provide documentation of Hepatitis B vaccine

Hepatitis B vaccines: **Vaccine Brand Name:**_____ 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**

Tuberculosis Testing **Campus Housing? Yes____ No____** **International Student? Yes___ No___**

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. Chest x-ray cannot be submitted in lieu of IGRA blood test.

PPD Date Given:_____/_____/_____ M D Y PPD Date Read:_____/_____/_____ M D Y PPD Result:_____ mm

IGRA Test performed:_____ Date of Lab Test_____/_____/_____ M D Y **Attach lab report**

Strongly Recommended Immunizations:

Tetanus (Td or T-Dap please circle): Date: _____/_____/_____ M D Y

Varicella (Chickenpox): Dose #1 _____/_____/_____ M D Y Dose #2 _____/_____/_____ M D Y

COVID-19 Vaccines: If vaccinated please upload vaccine card

FORM WILL NOT BE ACCEPTED IF SIGNATURE AND DATE PRECEDE ANY IMMUNIZATION DATE OR TEST RESULTS

Health Care Provider 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/.

Caldwell University Health Services, 20 Bloomfield Ave., Caldwell, NJ 07006. Phone 973-618-3319

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.

NOTE: Physicians signature NOT required for commuter students (not living on campus) 25 years or older.

Student Name:	**Student ID Number:**	**DOB:**
Student Signature:	**Parent Signature (if under 18):**	

Please check the applicable boxes below:

	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**
☐ **≤ 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 FACTORS		
☐ 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**

Please enter vaccination dates as applicable:

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®

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

FORM WILL NOT BE ACCEPTED IF SIGNATURE AND DATE PRECEDE ANY IMMUNIZATION DATE

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