

**DUE DATE:**

EOF Summer Program	<b>June 1<sup>st</sup></b>
Fall Semester Entry	<b>July 15<sup>th</sup></b>
Spring Semester Entry	<b>Dec. 15<sup>th</sup></b>

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.

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 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

## Helpful Tips for completing the Caldwell University Health form.

### Page 1.

- To be completed by student.
- Please check if you will be a resident student or a commuter student.
- Include permanent home address and the address at which you will be living while in NJ if commuting to campus from an off campus location.
- International students, please include your U.S. cell phone number.
- Be sure to include two emergency contacts and their contact information.

### Page 2.

- To be completed by student.
- Complete name at the top of form

### Page 3.

- To be completed by physician.
- Physician to complete all of the information including vital signs and to answer all questions on the form.
- The physician must sign and date the form and put their office stamp at the bottom of the page.

### Page 4.

- Student to complete all information boxes at the top of the form including cell phone number.
- Physician must complete remainder of the form including all dates of immunizations.
- If you are submitting blood titers as proof of immunity the complete lab report must be attached.
- The physician must sign and date where indicated at the bottom of the form. The date of the physician's signature cannot precede any dates of vaccinations on the form.
- The physician must put their office stamp at the bottom of the form.
- Some other records of immunization are recognized by the NJ State Department of Health and can be attached to this page. Some examples of acceptable documents are K-12 school immunization records or state immunization records.

### Page 5.

- Student to complete name where indicated.
- Tuberculosis testing is required for all students who will live in campus housing and for ALL INTERNATIONAL STUDENTS IRREGARDLESS OF WHERE THEY WILL BE LIVING. If starting in Fall, test must not be before March 1<sup>st</sup>. If starting in Spring, test must not be before August 1<sup>st</sup>.
- Domestic students can have either Tuberculosis skin testing or an IGRA laboratory test.
- International students MUST have an IGRA laboratory test.
- If doing a skin test, healthcare professional must sign, date, and stamp form at each stage of the testing process.
- If doing lab work, the complete lab report must be attached to the form.
- If either testing is positive, a chest x-ray is required. The chest x-ray report must be attached.

### Page 6.

- Student must complete and sign all sections at the top of the page.
- All campus housing students must be vaccinated against Meningitis ACYW according to the ACIP guidelines.
- Physician must include all dates of required meningitis vaccination or attach acceptable immunization document.
- Physician must sign, date, and stamp the bottom of the page.



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

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

**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:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **US Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Current NJ/USA Address (if NOT living at home or on campus):** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**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 (or that of my guardian if under 18 years old) indicates that: I (or my guardian on my behalf) 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. I understand that if I am a minor, I may be required by medical providers and/or Health Services to contact a legal parent or guardian to provide consent at the time of each visit. I understand that Health Services staff cannot provide treatment until my health forms are complete. I understand that if Health Services staff cannot provide treatment I will be referred to an off-campus provider and assume full financial responsibility for fees incurred.

\_\_\_\_\_  
 Signature of Student Date

\_\_\_\_\_  
 Signature of Parent/Guardian Date  
 (if student is under 18)

**Digital signature NOT accepted**

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

<b>MEDICAL HISTORY (to be completed by student)</b>					
<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 USEAGE</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		
Psychotropic medications and dose (please list): _____ _____ _____			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		
<b>FAMILY HISTORY-Circle all that apply</b>					
<b>FATHER</b> Living/Deceased			<b>MOTHER</b> Living/Deceased		
High Blood Pressure	Heart Disease		High Blood Pressure	Heart Disease	
Cancer	Diabetes	Thyroid Disease	Cancer	Diabetes	Thyroid Disease



<b>Student's Name:</b> _____ (Last) (First)	<b>Birth Date:</b> ____/____/____ M D Y
<b>Caldwell ID:</b> _____	<b>Cell Phone#:</b> _____

**REQUIRED IMMUNIZATIONS: TO BE COMPLETED BY PHYSICIAN**

<b>MMR (2 dose series):</b>  <b>Dose #1:</b> ____/____/____ M D Y  <b>Dose #2:</b> ____/____/____ M D Y	<b>OR</b>	<b>Measles: Dose #1:</b> ____/____/____ M D Y <b>Dose #2:</b> ____/____/____ M D Y  <b>Mumps: Dose #1:</b> ____/____/____ M D Y  <b>Rubella: Dose #1:</b> ____/____/____ M D Y
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New Jersey State law requires that ALL students (registered for 12 or more credits) provide documentation of a completed Hepatitis B vaccine series

**Hepatitis B (3 dose series):**      **Vaccine Brand Name (if known):** \_\_\_\_\_

**Dose #1:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Dose #2:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Dose #3:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M D Y                                      M D Y                                      M D Y

<b>D-TAP (age 11-12):</b> ____/____/____ M D Y	<b>OR</b>	<b>T-DAP (after age 13):</b> ____/____/____ M D Y
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**Varicella (Chicken Pox) (2 dose series):**

**Dose #1:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Dose #2:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M D Y                                      M D Y

**Polio:**  
**If completed in childhood (4 dose series):**

**Dose #1:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Dose #2:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Dose #3:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Dose #4:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M D y                                      M D Y                                      M D y                                      M D Y

**If NOT completed in childhood (3 dose series):**

**Dose #1:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Dose #2:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Dose #3:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M D y                                      M D Y                                      M D y

**Titer results may satisfy some immunization requirements. Please attach the laboratory report for review.**

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

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OFFICE STAMP (REQUIRED):**

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

**Tuberculosis Testing**

TB testing must have been performed **within 6 months** prior to entering campus housing or the start of the semester for international commuters. If starting in Fall, test must not be before March 1<sup>st</sup>. If starting in Spring, test must not be before August 1<sup>st</sup>.

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 TB testing.

- **Campus Housing? Yes \_\_\_ No \_\_\_**

**US Residents: Required for students entering on-campus housing.** Testing can be either an IGRA or a PPD

- **International Student? Yes \_\_\_ No \_\_\_**

**ALL International students: Testing must be an IGRA Lab test** (TB skin testing will not be accepted for international students.)

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PPD placed: \_\_\_\_\_  
site date time

\_\_\_\_\_  
Signature, Title Office Stamp

PPD read: \_\_\_\_\_  
site date time

Result in mm: \_\_\_\_\_

\_\_\_\_\_  
Signature, Title Office Stamp

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IGRA Test performed: \_\_\_\_\_  
Yes No

Date Lab work done: \_\_\_\_\_ **Attach IGRA Lab report**  
date

## **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.

**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.

**By signing below I acknowledge that I have received information about Meningitis.**

Student Name:	Student ID Number:	DOB:
Student Signature: (Digital signature NOT accepted)	Parent Signature (if under 18):	

Please check the applicable boxes below:

	<u>MenACYW Requirement</u>	<u>MenB requirement</u>
<input type="checkbox"/> ALL Students living in on-campus housing regardless of age (Must be administered after age 16 and within 5 years of entering campus housing) $\Rightarrow$	Vaccine required (administered after age 16)	X Vaccine not required
<input type="checkbox"/> Commuter students $\leq$ 18 years of age, not at increased risk (see below) $\Rightarrow$	Vaccine required (administered after age 16)	Vaccine not required
<input type="checkbox"/> Commuter students $\geq$ 19 years of age, not at increased risk (see below) $\Rightarrow$	Vaccine not required	Vaccine not required
<b>INCREASED RISK FACTORS</b>		
<input type="checkbox"/> Complement component deficiency or use of medication known as complement inhibitor (e.g. eculizumab) $\Rightarrow$	Vaccine required	Vaccine required
<input type="checkbox"/> No spleen, or problem with spleen- including sickle cell disease $\Rightarrow$	Vaccine required	Vaccine required
<input type="checkbox"/> HIV infection $\Rightarrow$	Vaccine required	Vaccine not required
<input type="checkbox"/> Work in a laboratory with meningococcal bacteria (Neisseria meningitis) $\Rightarrow$	Vaccine required	Vaccine required

Please enter required vaccination dates: TO BE COMPLETED BY PHYSICIAN

<p><b>Meningococcal vaccine A,C,Y,W-135:</b> Dose #1 (at age 11-12 yr) ___/___/___ Dose #2 (after age 16) ___/___/___</p> <p style="text-align: center;">M D Y M D Y</p>
<p><b>Meningococcal B:</b> Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___</p> <p style="text-align: center;">M D Y M D Y M D Y</p> <p>Which one: <input type="checkbox"/> Bexsero® <input type="checkbox"/> Trumenba®</p>

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

**NOTE: If over 25 AND a commuter, physicians' signature is not required.**

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

**Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**OFFICE STAMP (REQUIRED):**