Saint Elizabeth University
STEU.EDU

Traditional Undergraduate Students - State of N.J. & Saint Elizabeth University Medical Requirements

TIME SENSITIVE REQUIREMENTS

DEADLINE: **IMMEDIATELY** prior to **JUNE 15TH** (FALL SEMESTER) **DECEMBER 1ST** (SPRING SEMESTER)

ALL HEALTH REQUIREMENTS MUST BE COMPLETED TO ATTEND CLASS

NON COMPLIANCE WILL LEAD TO FINANCIAL FEES $350, REGISTRATION HOLDS AND INABILITY TO RESIDE IN CAMPUS HOUSING

Complete and send or upload to: https://www.steu.edu/student-life/health-services/secure-file-upload

Health Services – Founders Hall, 2 Convent Road, Morristown, New Jersey 07960

Phone: 973-290-4132 Fax: 973-290-4182 Immunization Information Line: 973-290-4388 ext 4388

The Student is responsible for ensuring that all ***required forms*** are completed and ***the physician*** completes and signs all medical information*.* ***PLEASE READ and FOLLOW ALL INSTRUCTIONS CAREFULLY***

- ❑ **REQUIRED FORM A** (pgs. 1-6) **- HEALTH FORM**
  - ❑ **Identification Data** (A1)
    - Emergency Information
    - Insurance Information/copy of insurance card
    - Parental Endorsement for Medical Care (as indicated by age)
    - o **History** (A2) ***Must be within one year of entrance.***

- ❑ **REQUIRED FORM *B* - IMMUNIZATION RECORD**
  - Review, obtain and complete all required vaccines/ **signed by your physician**
  - **All students must fulfill the vaccine requirements *prior* to entrance.**
- ❑ **REQUIRED FORM *C* - MENINGITIS INFORMATION SHEET**
  - All students must read the information about meningitis & the vaccines
  - ❑ **All students must fill in, sign, date and submit the meningitis information sheet**

Athletes Only

- All potential athletes must have Form A completed prior to participation**.**
- EKG and sickle cell testing is mandatory. Please attached both results to Form A.
- Please refer to the *Athletics' website – Inside Athletics – Sports Medicine/Physicals for forms and additional information*
  - For all other questions please call 973-290-4288 or email mpawlusiak@steu.edu

Where can you obtain an acceptable record of immunization?

High school, college, university, healthcare provider, family records, employee health, state records

Acceptable Records?

The Record must show exact dates (month, day, and year) and be signed/stamped by your physician or health care provider.

Start Immediately. Time Sensitive Requirements!

Immunization Requirements

History and Physical must be WITHIN ONE YEAR OF ENTRANCE

- ***MMR*** *vaccine* ***2 doses*** **or blood work** *to show evidence of immunity-* ***Required***
  - ***Copy of lab report required within 5 years for evidence of immunity***
  - *Equivocal titers are considered negative*
- ***Meningitis*** **serogroup ACWY** ***vaccine*** - ***Required***
  - ***Final dose must be at or after the age of 16 years AND within 5 years of entry***
  - **All students** less than or equal to **23** Years old – ***Required***
  - **All resident students -** ***Required***
- **Meningitis Information Sheet** – ***Required***
- ***Hepatitis B vaccine*** **– 3 dose series** - ***Required***
  - If history of Hepatitis B disease – evidence of immunity is required
  - ***Copy of lab report required for titers***
  - 2 dose series of Hepislav-B for >18 years old also acceptable
- ***Interferon-gamma release assay tests (IGRA) or PPD /Mantoux testing***
  - **Required within** ***one year*** **of entry**
  - ***RESULTS FOR PPD MUST BE IN MM OF INDURATION (record date planted/date read)***

Highly Recommended and Optional Vaccines

- ***Meningitis serogroup B*** vaccine – ***Highly Recommended***
  All students ≤ 23 years and further recommendation as per the CDC
- ***Tdap- Highly Recommended*** *– 1 dose*
  - Td or Tdap *within 10 years required*
  - Primary series completed
- ***Polio vaccine- Highly Recommended*** - Primary series completed
- **COVID19-** ***Highly Recommended*** as per CDC and ACIP
- **Flu-** ***Highly recommended*** Seasonal
- **Varicella-** ***Highly recommended*** Required by Nutrition, PA, and Nursing Departments
- **HPV-*****Highly recommended*** Preventative health care
- **Hepatitis A-** As recommended by the CDC (6-12 months between doses 1 and 2)

These vaccines are not required but to promote preventive health care and management, these vaccines should be discussed with your physician.

Without the above COMPLETE documented health records and required immunizations, you will be unable to reside in campus housing, attend class, register for future classes and incur financial fines of $350.

Note:
Medical records are strictly confidential and are used exclusively by the Student Health Service as required by Federal and State Law. ***Be aware immunization records are an exception and are not confidential.*** *Your immunization records will be made available to state inspections and select university offices.*

Psychological and Accessibility Services

The health form that you and your physician complete will be accessible only to STEU Health Services staff due to state and federal privacy laws (HIPAA). They cannot be shared with other St. Elizabeth University departments without proper permission as required by law.

If you require accessibility accommodations, **you must** self identify and provide appropriate documentation directly to **Sarah David, Accessibility Services Coordinator, at 973-290-4261 or** sdavid@steu.edu.

Accessibilities Services
Saint Elizabeth University
Mahoney Library
2 Convent Road
Morristown, New Jersey 07690

If you have a mental health condition and/or take psychiatric medication and want Counseling Services to be aware of your history, **you must** self identify and provide appropriate documentation directly to **Maryum Raheem, Mental Health Clinician, at 973-290-4134 or mraheem@steu.edu**

Counseling Services
Saint Elizabeth University
Wellness Center
2 Convent Road
Morristown, New Jersey 07690

If you choose to sign release of information forms, these three service areas can coordinate your care. For further details or questions, please contact these individual offices

COMPLETED RECORDS MUST BE RECEIVED BY June 15th
SEND RECORDS BY MAIL, FAX OR UPLOAD TO:
https://www.steu.edu/student-life/health-services/secure-file-upload
Health Services – Founders Hall
Saint Elizabeth University
2 Convent Road. Morristown, NJ, 07960
PHONE: 973-290-4175 or 4132 **FAX:** *973-290-4182*
Any questions, please call Immunization Information Line 973-290-4388 ext 4388
Email immunization@steu.edu.

REQUIRED FORM A

REQUIRED FORM A – HEALTH FORM (6 PAGES) – TRADITIONAL UNDERGRADUATE STUDENTS

Health Services – Founders Hall - 2 Convent Road - Morristown, NJ 07960
Phone Number: ***973-290-4132, 4175*** Fax Number: ***973-290-4182*** Immunization Information Number: ***973-290-4388***

IDENTIFICATION DATA

Name ____ ______/_____/________
Last First Middle Date of Birth (mm/dd/yyyy)

Home Address ____
Street City State Zip Code

State/Country of Origin __________Telephone ______________________ Email ______________________

First Semester Enrolled ___/___ (M/Y) Expected Graduation Date ___/___ (M/Y) Freshman ____ Transfer ____

SEU Leave Of Absence ____/____ (M/Y) SEU Withdrawal ____/____ (M/Y) SEU Dismissal ____/____ (M/Y)

HEALTH INSURANCE COVERAGE

Please include a **copy** of your **present health insurance card front and back.**

____
Insurance Company Address Group and Policy#

____
Subscriber's Name Subscriber's DOB Subscriber's SS #

EMERGENCY INFORMATION – contact to be notified in case of emergency

Name ______________________________________ Relationship______________________
Home Address____________________________________ Tel.# ______________________

Please list another person who can be contacted in case the above person cannot be reached.
Name ______________________ Relationship ________________Tel.# ______________________

PARENTAL ENDORSEMENT FOR MEDICAL CARE

Permission for medical care of minors (a parent or guardian's signature is required)
For students under the age of 18: I hereby give permission to the medical and psychological staff of Saint Elizabeth Health Services to examine and treat my minor child for all medical problems and injuries that may occur while they are on campus.

DATE: ____________ SIGNATURE: ______________________________RELATIONSHIP: ______________________

SOURCES OF HEALTHCARE

List the names, addresses and telephone numbers of** physicians, dentists, psychologists, or other health care providers **you now consult.

Name/specialty	
Address	
City, State	
Telephone	Fax

Name/specialty	
Address	
City, State	
Telephone	Fax

Print Full Name: ____ **Date of Birth**: ____________________

Medication		
Name of medication	**Dosage**	**Reason for Taking**

Allergies	
Allergen (e.g. Medications, Insects, Food, etc.)	**Reaction** (e.g. Anaphylaxis, Rash, Vomiting, etc.)

PHQ-9 Questionnaire				
Directions: Circle the number that corresponds with how often over the last two weeks you felt	**Not at all**	**Several days**	**More than half the days**	**Mostly everyday**
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thought that you would be better off dead, or of hurting yourself	0	1	2	3
Totals				
Score				

Print Full Name: ____ **Date of Birth** ______________________
Directions: Please check "Yes" "No" to the following questions below.

General Medical History	Yes	No
Have you ever been denied or restricted from participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify. ☐ Anemia ☐ Asthma ☐ Diabetes ☐ Infections Other: ______________________		
Have you ever used or are currently using an inhaler or take asthma medication?		
Have you ever gone to the hospital? Specify the reason on the next page.		
Have you ever had surgery?		
Were you born without or are you missing a kidney, an eye, a testicle(males), your spleen, or any other organ?		
Do you have groin pain or painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis(mono) within the last month?		
Do you have any rashes, pressure sores, or other skin problems?		
Have you had herpes or MRSA skin infection?		
Have you ever had a head injury or concussion?		
Have you had a hit or blow to the head that resulted in unconsciousness, memory loss, confusion or prolonged headaches?		
Have you ever had any numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Have you ever been unable to move your arms or legs after being hit or from falling?		
Have you ever become ill while exercising in the heat?		
Do you get muscle cramps often while exercising?		
Do you or someone in your family have sickle cell disease?		
Have you had any problems with your vision or eyes?		
Have you had any eye injuries?		
Do you wear glasses or contact lenses?		
Have you ever had an eating disorder?		
Do you have any concerns that you would like to discuss with doctor?		
Have you been diagnosed with coronavirus (COVID-19)?		
If diagnosed with Coronavirus (COVID-19) were you symptomatic?		
If diagnosed with Coronavirus (COVID-19) were you hospitalized?		

Females Health History	Yes	No
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months? ( )		

Family Health History	Yes	No
Has anyone in your family died from heart problems/complication or had an unexpected or unexplained sudden death before age 50?		
Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		

Cardiac History	Yes	No
Have you ever passed out or nearly passed out during or after exercising?		
Have you ever had any chest tightness, pain, or pressure during or after exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection ☐ Kawaski disease ☐ Other: ____________		
Have you ever had a test ordered for your heart? (ECG, EKG, echocardiogram)		
Do you get more tired or short or breath more quickly than your friends during exercise?		
Have you ever had an unexplained seizure?		

Musculoskeletal History	Yes	No
Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
Have you ever had any broken or fractured bones or dislocated joints?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
Have you ever had a stress fracture?		
Have you ever been told that you have or told you require an x-ray for neck instability or atlantoaxial instability?		
Do you regularly use a brace, orthotics, or other assistive devices?		
Do any of your joints become painful, swollen, feel warm, or look red?		
Do you have a history of juvenile arthritis or connective tissue disease?		

Print Full Name: ____

Directions: If you answered "yes" to any of the question on the previous page, please explain to the best of your knowledge below on the lines provided.

____
____
____
____
____
____
____
____
____
____
____
____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

____

Date Student Name (Printed) Signature of Student

Physical Examination Form

Print Full Name____ Gender ______________ Age______ Date of Birth_____________

PHYSCIAN REMINDER

1. Consider additional questions on more sensitive issues
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

EXAMINATION		
Height: **Weight:** ☐ **Male** ☐ **Female**		
BP (/) HR: **Vision R 20/** **L 20/**	**Corrected Y N**	
MEDICAL	NORMAL	ABNORMAL FINDINGS COMMENTS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodctyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse		
Pulse • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary(males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

- Consider EKG, echocardiogram, and referral to cardiology for abnormal cardiac, history of exam.
- Consider GU exam if in private setting. Having third party present is recommended.
- Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Signature of physician, APN, PA____ Date of Exam ______________________________________

Physical Evaluation Clearance Form

Print Full Name____ Sex M F Age________ Date of Birth______________

 Cleared for all sports without restriction

 Cleared for all sports without restriction with recommendations for further evaluation or treatment for____

 Not Cleared

- Pending further evaluation
- For any sports
- For certain sports____

Recommendations
____
____
____
____

EMERGENCY INFORAMITON

Allergies
____
____
____
____
____

Other information
____
____
____
____
____

OFFICE STAMP

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Office Name ____

Address____ Phone____

Printed name of physician, advance practice nurse (APN), physician assistant(PA)____

Signature of physician, APN, PA____ Date of Exam ____

REQUIRED FORM B (1) – IMMUNIZATION RECORD ***START IMMEDIATELY – TIME SENSITIVE REQUIREMENTS!***

SAINT ELIZABETH UNIVERSITY TRADITIONAL UNDERGRADUATE STUDENTS

Name___________________________________ Class (year)___________ Date of Birth___/____/______

REQUIRED VACCINES

READ ALL INSTRUCTIONS CAREFULLY

	Dates Given	**Saint Elizabeth University and NJ State Requirements**
MMR	#1 ___/ ___/ ___ #2 ___/ ___/ ___ **1**st dose given after **1**st birthday. Minimum of 4 weeks between doses	**2** doses or ***positive titers*** ***(must include copy of lab report within five years)*** **Equivocal titers are considered negative** Option of combined MMR OR **2** individual vaccine doses of measles, mumps, and rubella vaccines. Single dose vaccines are not manufactured any longer
or Measles Mumps Rubella	#1 ___/ ___/ ___ #2 ___/ ___/ ___ **OR Positive Titer Date**: ___/ ___/___***lab report required*** #1 ___/ ___/ ___ #2___/___/ ___ **OR Positive Titer Date ___/___ /___** ***lab report required*** #1___/___/ ___ #2___/___ /___ **OR Positive Titer Date: ___ /___ /__*lab report required***	
Meningitis Vaccine Serogroup **ACWY** **(required)** **(≥ age 16)**	#1 ___/ ___/ ___ **#2 ___/ ___/ ___ *(≥ age 16)*** ❑ **Menomune** ❑ **Menactra** ❑ **Menveo**	**All** students ≤ 23 years. **All** resident students ***Final dose must be at or after the age of 16 years old AND within five years of entry*** **Further recommendation as per the CDC**
Meningitis Information Sheet	***Meningococcal information sheet fill in, sign, date and submit (Form C)***	**All students must read sign and submit meningococcal information sheet**
Hepatitis B	#1 ___/ ___/ ___ #2 ___/ ___/ ___ #3 ___/ ___/___ OR Positive Titer Date: ___/ ___/ ___ ***lab report required*** □ **Energrix B** □ **Recombivax B** □ **Heplisav B**	**3 doses** or **positive titer** *(must include copy of lab reports)* Minimum of **4 weeks** between *doses 1 and 2* (for2dose series) Minimum of **8 weeks** between *doses 2 and 3* Minimum of **16 weeks** between *doses 1 and 3*
Also **Required** (within the past year) **Interferon-gamma release assay test (IGRA)** **OR** **PPD / Mantoux**	Interferon-gamma release assay tests (IGRA) ___/___/___ ❑ pos. ❑ neg. ***lab report required*** **Or** PPD ___ /___ /___ ___/___/___ ***result*** ___***mm*** ***Planted*** ***Read*** ***Number*** Positive PPD in past ___/___/___ BCG history ___/___/___ If PPD or Inteferon-gamma release assay tests (IGRA) is positive, chest x-ray is required: **chest x ray ___ / ___ / ___** ❑ normal ❑ abnormal INH treatment began ___/___/___ completed ___/___/___	Must send copy of Interferon-gamma release assay tests (IGRA) report **Result must be in:** **mm of induration** **WITHIN ONE YEAR** **must include planted and read dates** Must send **copy of Chest X-Ray report**

FORM B (2) IMMUNIZATION RECORD

RECOMMENDED VACCINES	Dates Given	Recommendations
Meningitis Vaccine Serogroup **B (Highly Recommended)**	#1 ___/ ___/ ___ #2 ___/ ___/ ___ #3 ___/ ___/ ___ ❑ **Trumenba** ❑ **Bexsero**	**All** students ≤ 23 years. **Further recommendation as per the CDC**
Tdap (Highly Recommended) Td Completed primary series	❑Tdap ___/___/___ ❑Td ___/___/___ ❑DTP ❑DT ___/___/___	**Tdap 1 dose required** Td or Tdap within 10 years
Polio (Highly Recommended)	Primary series: ❑ Oral ❑ Injectable Most recent booster : ___/___/___	Primary series
Varicella (Chicken Pox) **(Highly Recommended)**	#1 ___/___/___ #2 __/ __/ ___ OR Positive Titer Date: ___/ ___/ ___ History of disease ❑No ❑ Yes Date ____ / ___	Strong Recommendation 2 doses varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses if age 13 or older ***Required by Nutrition, PA, and Nursing Departments***
HPV (Highly Recommended)	#1___/___/___ #2___/___/___ #3___/___/___ ❑Gardasil ❑Cervarix ❑Gardasil-9	Strong Recommendation Preventative health care
Flu (Highly Recommended)	___/____/___	Seasonal-**Highly recommended**
COVID (Highly Recommended)	#1___/____/___ #2___/___/___#3___/___/___ ❑Pfizer ❑Moderna ❑Johnson and Johnson ❑other	**Highly Recommended**
Hepatitis A	#1 ___/ ___/ ___ #2 ___/ ___/ ___	As recommended by the CDC 6-12 months between doses 1 and 2

HEALTH CARE PROVIDER

________________________ ______________________________ ___/___/___
Signature Print Name Date

__________________________ _____________ __________ ________
Address City State Zip

___________________ ___________________
Telephone Fax

Send Records by mail, fax or upload to:

https://www.steu.edu/student-life/health-services/secure-file-upload

Saint Elizabeth University
Health Services – Founders Hall
2 Convent Road, Morristown, N.J. 07960
PHONE: 973-290-4175 or 4132 **FAX:** 973-290-4182

Any questions, call Immunization Information Line: 973-290-4388 ext 4388 / immunization@steu.edu

REQUIRED FORM # C MENINGITIS INFORMATION SHEET REQUIRED FOR ALL STUDENTS

Meningococcal Disease among College Students
(Read about meningitis and the vaccine on the VACCINE INFORMATION STATEMENT)

In accordance with New Jersey State Law and the Saint Elizabeth University, all students must complete and return this form to the address below.

1) The college is to provide information about meningococcal meningitis, the disease, its severity, causes, disease prevention, treatment and the availability of the vaccine to prevent disease to all their students prior to matriculation (please see attached Meningococcal Disease Information Statement)
2) Meningitis Vaccine recommendations are as per ***The Center for Disease Control (CDC)*** and ***The Advisory Committee on Immunization Practices (ACIP).*** Read this information on the Vaccine Information Statement, "Who should get Meningococcal vaccine and when."
3) The college is to document the student's receipt of the meningococcal information and their decision whether or not to receive a meningitis vaccine.

Students may go to their private physician or other healthcare provider for administration of the meningitis vaccine. Arrangements can be made with the College of Saint Elizabeth Health Services for administration of the meningitis vaccine, if needed.

Complete and Sign all indicated below:

Yes **No** I have received information (What you need to know – Vaccine Information Statement) about meningitis, the vaccine, and its availability.

Yes **No** I have received the meningococcal (serogroup ACWY) vaccine. See Vaccine Information Statement as to "Meningococcal vaccines what you need to know".

Date #1 __/__/__ #2 __/__/__

Yes **No** I have received the meningitis (serogroup B) vaccine. See Vaccine Information Statement as to "Serogroup B Meningococcal vaccine: what you need to know".

Date #1 __/__/__ #2 __/__/__ #3__/__/__

Yes I have read the information regarding meningococcal meningitis disease. I understand the risks and benefits of immunization against meningococcal meningitis. I have decided at this time that I will NOT obtain the immunization against meningococcal meningitis disease. I understand that I may choose in the future to be immunized against meningococcal meningitis.

Name **(please print)** ______________________________ Date __________________________

Signature ____

(If student is under the age of 18 a parent's or guardian's signature is required)

This signature shall become part of the student's health record and is being required by New Jersey law, P.L. 2000c.25.

Send or upload this required form to:
https://www.steu.edu/student-life/health-services/secure-file-upload

Saint Elizabeth University
Health Services – Founders Hall
2 Convent Road
Morristown, NJ 07960
PHONE: (973) 290-4132, 4175 **FAX:** (973) 290-4182

Any questions, please call Immunization Information Line: 973-290-4388

Authorization to Release Medical and Immunization Records to Saint Elizabeth University Health Services

Date ____

Student Name ____

Date of Birth ______ / _______ /_______

Address ____

City _____________________________ State__________________________ Zip Code_____________________

Phone Number___________ - ____________ - ______________

I request and authorize (High School, University, Healthcare Provider, School Nurse)

____

to release (check all those that are indicated)

❑ Immunization Records ❑ Medical Records

to Health Services at Saint Elizabeth University. Please forward my records to:

Saint Elizabeth University
Health Services – Founders Hall
2 Convent Road
Morristown, NJ 07960
Attention: Priya Shrestha, Coordinator, Medical Records

If you wish, you may upload the information to www.steu.edu/meduploads or fax to (973) 290-4182. Questions/Concerns, please call (973) 290-4132 or 4175.

Signature /Date ____

Name of Parent or Guardian (if under 18) ____

Signature of Parent or Guardian (if under 18) ____

Relationship to patient ____