Graduate and Continuing Studies
State of NJ and Saint Elizabeth University Medical Requirements

TIME SENSITIVE REQUIREMENTS

**DEADLINE:** IMMEDIATELY
FALL SEMESTER – DUE JULY 1 or immediately upon enrollment
SPRING SEMESTER – DUE DECEMBER 1 or immediately upon enrollment

**ALL** HEALTH REQUIREMENTS MUST BE COMPLETED TO ATTEND CLASS
NON-COMPLIANCE WILL LEAD TO FINANCIAL FEES $350 AND REGISTRATION HOLDS

Complete and Send or upload to: [https://www.steu.edu/meduploads](https://www.steu.edu/meduploads)
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 the physician completes all medical information, which can be mailed or faxed to Health Services. **READ and FOLLOW ALL INSTRUCTIONS CAREFULLY**

- **REQUIRED FORM #1 - HEALTH FORM**
  - Identification Data (include maiden name, if appropriate)
  - Emergency Information

- **REQUIRED FORM #2 – IMMUNIZATION RECORD**
  - Physician to complete and sign
  - All students must fulfill the vaccine requirements prior to entrance

- **REQUIRED FORM #3 – MENINGITIS INFORMATION SHEET**
  - All students must read the information about meningitis & the vaccine
  - All students must sign and submit the meningitis information sheet

- **RECOMMENDED FORM #4 – HISTORY & PHYSICAL FORM**
  - Physician to complete and sign
  - Strongly recommended but not required
  - History and Physical within one year of entrance

**Immunization Records**
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, year) and be signed by your physician or health care provider.

**PLEASE NOTE:** Nursing, Foods and Nutrition, Psychology, Physician Assistant, Education Departments require additional health information. Please contact these departments for further instructions. Nursing forms are available at [https://www.steu.edu/medreqs](https://www.steu.edu/medreqs). All **RESIDENT STUDENTS** must complete the Traditional Undergraduate Medical Requirements and forms.

**Immunization Requirements**
- MMR vaccines - **REQUIRED**
2 doses MMR or 2 measles, 2 mumps, 2 rubella or evidence of immunity
- Required of all students born after 1956+
- First dose must be after the 1st birthday and vaccines are acceptable after 1968
- Between the two MMR doses, a minimum of 28 days is required.
- Single dose vaccines are not manufactured any longer.
- Copy of lab report for immunity done within 5 years
  - Be aware! DO NOT ASSUME PRESENT IMMUNITY if you do not have a record of 2 MMR’s
  - Equivocal titers are considered negative

- Hepatitis B vaccines - REQUIRED for all students with 12 or more credits (recommended for others)
  - 3 dose series for Recombivax (Merck) or Engerix-B (GSK)
  - Or 2 dose series with Heplisav-B (recombinant, adjuvanted)
    - Minimum of 4 weeks between doses 1 and 2 (for 2 and 3 dose series)
    - Minimum of 8 weeks between doses 2 and 3 (for 3 dose series)
    - Minimum of 16 weeks between doses 1 and 3 (for 3 dose series)
  - Or Evidence of immunity
    - Copy of lab report required for immunity

- Meningitis Information Sheet - REQUIRED

Recommended and Optional Vaccine
- Tdap, Flu, Varicella, HPV, Hepatitis A, Meningitis ACWY and B, Pneumococcal, HiB, Polio, Typhoid, Zoster, Yellow Fever

The history and physical, recommended and optional vaccines are not required. To promote preventive health care and management the physical and vaccines should be discussed with your physician.

Without the above COMPLETE documented health records and required immunizations you will INCUR FINANCIAL FEES $350, REGISTRATION HOLDS AND CLASS ATTENDANCE DELAYS

COMPLETED RECORDS MUST BE RECEIVED IMMEDIATELY
FALL SEMESTER - DUE July 1  
SPRING SEMESTER - DUE December 1

Upload Records to: https://www.steu.edu/meduploads
Health Services - Founders Hall
Saint Elizabeth University
2 Convent Road
Morristown, NJ, 07960
PHONE: 973-290-4132  FAX: 973-290-4182
Any questions, please call Immunization Information Line: 973-290-4388 ext 4388
immunization@steu.edu

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 medical records that you and your physician complete will be accessible only to SEU Health Services staff due to state and federal privacy laws (HIPAA). They cannot be shared with any SEU departments without proper permission as required by law.

If you require accessibility accommodations, you must self identify and provide appropriate documentation directly to the Accessibility Services Coordinator.
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 the appropriate documentation directly to the Director of Counseling Services.

Zsuzsa A. Nagy, MA, dr.univ., LCSW Director of Counseling Services
Counseling Services - Saint Elizabeth University
Founders Hall - 2 Convent Road
Morristown, New Jersey 07690
Phone: 973-290-4134
Email address: znagy@steu.edu

Should you choose to sign a release of information form, the above service areas can coordinate your care. For further details or questions, please contact the individual offices.
REQUIRED FORM #1 – HEALTH FORM Identification  Graduate /Continuing Studies

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 ext 4388

IDENTIFICATION DATA

Name _____________________________________________________________  _____________________________ / / ______
 Last /Maiden name First         Middle        Date of Birth

Home Address ___________________________________________________________
              Street             City               State             Zip Code
Country of Origin ___________________ Telephone __________________            __________________            __________________
cell           home

Email _____________________________@________________________________

Program/Degree________________________ Credits#_____ First Semester Enrolled ___/___ Expected Graduation Date ___/___
                          MM/YY                  MM/YY
Freshman _____ Transfer _____SEU Leave of Absence ___/___ SEU Withdrawal ___/___ SEU Dismissal ___/___
                        MM/YY                      MM/YY        MM/YY

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.# __________________ Home work/cell

Please list another person who can be contacted in case the above person cannot be reached.

Name ___________________________ Relationship ___________________________ Tel.# __________________

SOURCES OF HEALTHCARE
List the names, addresses and telephone numbers of Physicians, psychologists, or other health care providers you now consult.

<table>
<thead>
<tr>
<th>Name/specialty</th>
<th>Address</th>
<th>City, State</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/specialty</td>
<td>Address</td>
<td>City, State</td>
<td>Telephone</td>
<td>Fax</td>
</tr>
<tr>
<td>Name/specialty</td>
<td>Address</td>
<td>City, State</td>
<td>Telephone</td>
<td>Fax</td>
</tr>
</tbody>
</table>
REQUIRED FORM #2 (A)  IMMUNIZATION RECORD  GRADUATE AND CONTINUING STUDIES

Start Immediately-Time Sensitive Requirements

Name ___________________________________  Class (year) ____________  DOB _______/_____/_____

REQUered Vaccines

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>Read all instruction documents carefully</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Saint Elizabeth University and NJ State Requirements</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>#1  <em><strong>/</strong></em>/___  #2 <em><strong>/</strong></em>/___  Minimum of 4 weeks between doses 1st dose given after 1st birthday</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Or Measles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1  <em><strong>/</strong></em>/___  #2 <em><strong>/</strong></em>/___  OR Positive Titer Date: <em><strong>/</strong></em>/___ copy of lab report REQUIRED within 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1  <em><strong>/</strong></em>/___  #2 <em><strong>/</strong></em>/___  OR Positive Titer Date <em><strong>/</strong></em>/___ copy of lab report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rubella</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1___/<em><strong>/</strong></em>  #2___/<em><strong>/</strong></em>  OR Positive Titer Date: <em><strong>/</strong></em>/___ copy of lab report REQUIRED within 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meningitis Serogroup ACWY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1  <em><strong>/</strong></em>/___  #2 <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Menomune □ Menactra □ Menevo</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meningitis information sheet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ All students must read sign and submit meningitis information sheet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meningitis Serogroup B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1___/<em><strong>/</strong></em>  #2___/<em><strong>/</strong></em>  #3___/<em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Trumenba □ Bexsero</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Required for students with 12 or more credits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Recommended for all others)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1___/<em><strong>/</strong></em>  #2___/<em><strong>/</strong></em>  #3___/<em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Engerix B □ Recombivax B □ Heplisav B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RECOMMENDED VACCINES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inteferon-Gamma Release Assay tests (IGRA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Or PPD / Mantoux</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interferon-gamma release assay tests (IGRA) <em><strong>/</strong></em>/___  □ pos. □ neg. copy of report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Or PPD <em><strong>/</strong></em>/___  <em><strong>/</strong></em>/<em><strong>/</strong></em> result mm Planted Read Number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive PPD in past <em><strong>/</strong></em>/___ BCG history <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If PPD or Interferon-gamma release assay tests (IGRA) is positive, chest x-ray is required: chest x ray <em><strong>/</strong></em>/___ □ normal □ abnormal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>INH treatment began <em><strong>/</strong></em>/___ completed <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Must send copy of Interferon-gamma release assay tests (IGRA) report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result must be in mm of induration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WITHIN ONE YEAR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Required for Nutrition, Nursing, PA and Residents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Must send copy of Chest X-Ray report</td>
<td></td>
</tr>
</tbody>
</table>

Clinician Signature ___________________________  Print Name ___________________________  Date ______/_____/_____
### RECOMMENDED VACCINES - Immunization Form #2(B)

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap Td</td>
<td>Tdap <em><strong>/</strong></em>  Td <em><strong>/</strong></em></td>
<td>Tdap or Td Booster within last 10 years</td>
</tr>
<tr>
<td>Completed primary series</td>
<td>DTP DT <em><strong>/</strong></em>/___</td>
<td>1 dose of Tdap</td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td>Primary series, boosters as per CDC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Required for Nutrition, Nursing, PA and Residents</td>
</tr>
<tr>
<td>Varicella (Chicken pox)</td>
<td>#1___/<em><strong>/</strong></em> #2 <em><strong>/</strong></em></td>
<td>2 doses varicella vaccine or history of disease or positive titer</td>
</tr>
<tr>
<td></td>
<td>OR Positive Titer Date:</td>
<td>Minimum of 4 weeks between doses if age 13 or older</td>
</tr>
<tr>
<td></td>
<td><em><strong>/</strong></em>/___</td>
<td>Required by Nutrition and Nursing, PA Departments</td>
</tr>
<tr>
<td>HPV</td>
<td>#1___/<em><strong>/</strong></em> #2___/<em><strong>/</strong></em> #3___/<em><strong>/</strong></em></td>
<td>Preventative health care, as per the CDC</td>
</tr>
<tr>
<td>Hib</td>
<td><strong>/</strong>/___</td>
<td>Primary series completed, as per the CDC</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>#1___/<em><strong>/</strong></em> #2___/<em><strong>/</strong></em></td>
<td>As per the CDC 6-12 months between doses 1 and 2</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>As per the CDC Chronic health problems</td>
</tr>
<tr>
<td></td>
<td>Polysaccharide (PPV)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conjugate (PCV)</td>
<td></td>
</tr>
<tr>
<td>Zoster</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>As per the CDC</td>
</tr>
<tr>
<td>Flu</td>
<td>#1___/<em><strong>/</strong></em></td>
<td>Yearly seasonal, as per the CDC</td>
</tr>
</tbody>
</table>

### OPTIONAL VACCINES

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typhoid</td>
<td><strong>/</strong>/___</td>
<td>Travel as per the CDC</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>#1___/<strong>/</strong>_</td>
<td>Travel as per the CDC</td>
</tr>
</tbody>
</table>

### HEALTH CARE PROVIDER

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><em><strong>/</strong></em>/___</td>
</tr>
</tbody>
</table>

Address: __________________________  City: __________  State: __________  Zip: __________

Telephone: __________________________  Fax: __________________________

Send Records by mail, fax or upload to: [https://www.steu.edu/meduploads](https://www.steu.edu/meduploads)

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

imunization@steu.edu

GRADUATE & CONTINUING STUDIES - IMMUNIZATION RECORD REQUIRED FORM #2 July 2020

2 of 2
REQUIRED FORM #3  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 Saint Elizabeth University, all college students must complete and return this form to the address below.

1) The University 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 University 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 Saint Elizabeth University 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 __/__/__

☐ 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/meduploads

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 ext 4388

immunization@st.eu
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 _________________________________________________________
Meningococcal ACWY Vaccine: What You Need to Know

1 Why get vaccinated?

Meningococcal ACWY vaccine can help protect against meningococcal disease caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available that can help protect against serogroup B.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Anyone can get meningococcal disease but certain people are at increased risk, including:
- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of N. meningitidis, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

In addition to routine vaccination for adolescents, meningococcal ACWY vaccine is also recommended for certain groups of people:
- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- People with HIV
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called “persistent complement component deficiency”
- Anyone taking a type of drug called a complement inhibitor, such as eculizumab (also called Soliris®) or ravulizumab (also called Ultomiris®)
- Microbiologists who routinely work with isolates of N. meningitidis
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in residence halls
- U.S. military recruits

2 Meningococcal ACWY vaccine

Adolescents need 2 doses of a meningococcal ACWY vaccine:
- First dose: 11 or 12 year of age
- Second (booster) dose: 16 years of age

Tell your vaccine provider if the person getting the vaccine:
- Has had an allergic reaction after a previous dose of meningococcal ACWY vaccine, or has any severe, life-threatening allergies.

In some cases, your health care provider may decide to postpone meningococcal ACWY vaccination to a future visit.

Not much is known about the risks of this vaccine for a pregnant woman or breastfeeding mother. However, pregnancy or breastfeeding are not reasons to avoid meningococcal ACWY vaccination. A pregnant or breastfeeding woman should be vaccinated if otherwise indicated.
People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal ACWY vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

• Redness or soreness where the shot is given can happen after meningococcal ACWY vaccine.
• A small percentage of people who receive meningococcal ACWY vaccine experience muscle or joint pains.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call 1-800-822-7967. VAERS is only for reporting reactions, and VAERS staff do not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call 1-800-338-2382 to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

• Ask your healthcare provider.
• Call your local or state health department.
• Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC’s www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
Meningococcal ACWY Vaccines
8/15/2019    |    42 U.S.C. § 300aa-26
Meningococcal B Vaccine: What You Need to Know

1 Why get vaccinated?

Meningococcal B vaccine can help protect against meningococcal disease caused by serogroup B. A different meningococcal vaccine is available that can help protect against serogroups A, C, W, and Y.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Anyone can get meningococcal disease but certain people are at increased risk, including:
- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of N. meningitidis, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

Anyone with a rare immune system condition called “persistent complement component deficiency”
- Anyone taking a type of drug called a complement inhibitor, such as eculizumab (also called Soliris®) or ravulizumab (also called Ultomiris®)
- Microbiologists who routinely work with isolates of N. meningitidis

These vaccines may also be given to anyone 16 through 23 years old to provide short-term protection against most strains of serogroup B meningococcal disease; 16 through 18 years are the preferred ages for vaccination.

2 Meningococcal B vaccine

For best protection, more than 1 dose of a meningococcal B vaccine is needed. There are two meningococcal B vaccines available. The same vaccine must be used for all doses.

Meningococcal B vaccines are recommended for people 10 years or older who are at increased risk for serogroup B meningococcal disease, including:
- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:
- Has had an allergic reaction after a previous dose of meningococcal B vaccine, or has any severe, life-threatening allergies.
- Is pregnant or breastfeeding.

In some cases, your health care provider may decide to postpone meningococcal B vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal B vaccine.

Your health care provider can give you more information.
4 Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given, tiredness, fatigue, headache, muscle or joint pain, fever, chills, nausea, or diarrhea can happen after meningococcal B vaccine. Some of these reactions occur in more than half of the people who receive the vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call 1-800-822-7967. VAERS is only for reporting reactions, and VAERS staff do not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call 1-800-338-2382 to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC’s www.cdc.gov/vaccines

Vaccine Information Statement (Interim)  
Meningococcal B Vaccine  
8/15/2019  |  42 U.S.C. § 300aa-26
Name: ____________________________  Date of Birth: ______________________

Answer ALL questions  Explain All YES Answers

ALLERGY  Yes  No
Any significant allergy to food, medications, insects, pollen?  ☐ ☐
List known allergies and type of reaction to them:
Medication______________________________  ☐ ☐
Food______________________________  ☐ ☐
Environmental______________________________  ☐ ☐
Vaccines______________________________  ☐ ☐

MEDICATIONS:
Do you take any medications regularly, including herbals, supplements and over the counter drugs? ☐ ☐
Medications: List all medications and dosage that you take regularly prescription and non-prescription (ex. Anxiety, ADD, depression, birth control, asthma, diabetes etc.)

HOSPITALIZATION:
Have you ever been admitted to a hospital? ☐ ☐
Have you ever had surgery? ☐ ☐
Have you ever had any ER visits? ☐ ☐
Have you ever had any severe injury? ☐ ☐
List:

PAST ILLNESSES
Hepatitis, mononucleosis, childhood diseases, HIV ☐ ☐
Loss or absence of any body parts. ☐ ☐
Severe/frequent colds or flu ☐ ☐
Serious illness or injury ☐ ☐

ENT
Any problems with your eyes, ears, nose or throat? ☐ ☐
Hearing impairment ☐ ☐
Loss of eye or eyesight ☐ ☐

CARDIOVASCULAR:
Heart murmur/ palpitations ☐ ☐
Chest pain ☐ ☐
Rheumatic fever ☐ ☐
High blood pressure ☐ ☐
Irregular heartbeat ☐ ☐
Blood clots (not menstrual clots) ☐ ☐
Enlarged heart ☐ ☐
Mitral valve prolapse ☐ ☐
Fainting ☐ ☐

RESPIRATORY:  Yes  No
Asthma ☐ ☐
Tuberculosis ☐ ☐
Chest infection (pneumonia) ☐ ☐
Do you smoke cigarettes? ☐ ☐
How many?  How long? ____________
Shortness of breath ☐ ☐
Wheezing ☐ ☐
Chronic cough ☐ ☐

SKIN
Any problems with your skin? ☐ ☐
Skin rashes ☐ ☐
Acne ☐ ☐
Eczema ☐ ☐

ENDOCRINE
Thyroid disease ☐ ☐
Diabetes ☐ ☐

URINARY
Impaired function of any part of your urinary tract ☐ ☐
Loss of a kidney ☐ ☐
Recurrent urinary infection ☐ ☐
Kidney Infection ☐ ☐
Kidney stones ☐ ☐

MENTAL HEALTH
Any problems with your emotional health, requiring any form of therapy, including medications? ☐ ☐
Did you ever lie to anyone about your gambling? ☐ ☐
Does anyone presently in your life hurt you or make you feel afraid? ☐ ☐
History of depression? ☐ ☐
History of self harm or harm to others? ☐ ☐
History of abuse physically, emotionally or sexually? ☐ ☐
Learning disabilities? ☐ ☐

DRUG AND ALCOHOL USAGE
Have you ever felt you should cut down on your drinking? ☐ ☐
Have people annoyed you by criticizing your drinking? ☐ ☐
Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover? ☐ ☐
Smoke cigarettes? ☐ ☐
Please give specific information about drug usage (ex. Marijuana, pain medication, ecstasy)
**FAMILY HISTORY completed by student**

Check the following conditions which have appeared in your immediate family, indicating the person’s relationship to you. (Ex. Father Cancer)

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Sickle cell anemia / trait</th>
<th>Learning disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Heart Disease</td>
<td>Depression</td>
</tr>
<tr>
<td>Bleeding problems</td>
<td>Sudden death before age 50</td>
<td>Mental Illness</td>
</tr>
<tr>
<td>Cancer or Tumor</td>
<td>Stroke</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Kidney Disease / Bladder Disease</td>
<td>GYN Disorders</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Thyroid Disease</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Alcoholism / Drug Abuse</td>
<td>Seizure</td>
</tr>
</tbody>
</table>

Are your parents living? ______ # of brothers living ______ # of sisters living ______

If deceased, give relationship and cause of death and age of death

---

**To the Student: I certify that the statements are true to the best of my knowledge.**

Student Signature: ___________________________ print name ___________________________ Date: ___/___/____

**History Reviewed by Physician - Signature:** ___________________________ Date: ___/___/____
Physical Examination

Health History must be reviewed by the physician
Physical exam to be completed by the physician and performed within one year prior to entrance to the University

Patient Name __________________________ Sex M/F Date of Birth _______ DATE OF EXAM __/__/____

Vision: uncorrected Right 20/____ Left 20/____; with glasses/contacts Right 20/____ Left 20/____

Hearing: normal □ Yes □ No Abnormal _______________________________________________________

Height _______ Weight _______ BP _______ P _______ Resp _______ Peak Flow (as indicated) __________

<table>
<thead>
<tr>
<th>System</th>
<th>Satisfactory</th>
<th>Describe Abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose, throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck, thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest, lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen, liver, kidneys, spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphatic’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td></td>
<td></td>
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<tr>
<td>Pelvic (if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities, back, spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joints</td>
<td></td>
<td></td>
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<tr>
<td>Neurological</td>
<td></td>
<td></td>
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<tr>
<td>Psychological</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Laboratory Tests: URINALYSIS

BLOOD Cholesterol (Fasting) _______ CBC _______ Sickle Trait Screening and EKG (for athletes) _______
Additional labs as indicated ________________________________________________________________
Include copy of lab results

Impression/Diagnosis/Plan: recommendations, continuing treatment, restriction, medications should be noted : (attach as needed)

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Applicant may participate in University activities: including sports, physical education and intramurals
☐ Without restriction
☐ With the following restrictions and reason: __________________________________________________________

History Reviewed & Student Examined by:
Physician name (print): __________________________ Date ___________________
Signature/stamp ________________________________________________
Address _____________________________________________________________________________________
Phone __________________ Fax ________________