Please download and print a copy of the Medical Requirement forms for The NURSING Program, which includes the following items:

1. Required Forms Checklist and Instructions for Medical Forms
2. Required Form A - Health Form Identification, History, Physical, Health Care Provider Attestation
3. Required Form B - Immunization Record
4. Required Form C - Meningitis Information Sheet and Vaccine information
5. Required Form D – Authorization to Release Health, Immunization, Laboratory, Testing and TB Screenings

The Student is responsible for ensuring that all required forms are completed and the physician completes all medical information.

Please read the instructions carefully; complete and send, fax or upload a copy of all required forms to

Health Services College of Saint Elizabeth,  
Founders Hall,  
2 Convent Road,  
Morristown, NJ 07960  
immunization@cse.edu  
Phone: 973-290-4132  
Fax: 973-290-4182  
upload: https://www.cse.edu/student-life/health-services/secure-file-upload

For questions about nursing medical requirements and clinical clearance please contact the nursing department

Professor Patricia Ricci-Allegra  
(973) 290-4570  
prallegra@cse.edu  
Nursing  
Health and Immunizations  
College of Saint Elizabeth,  
2 Convent Road,  
Morristown NJ 07960
TIME SENSITIVE REQUIREMENTS

DEADLINE: IMMEDIATELY - prior to June 1st for fall semester

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

READ and FOLLOW ALL INSTRUCTIONS CAREFULLY

Complete and send to Health Services:

Health Services, College of Saint Elizabeth, Founders Hall, 2 Convent Road, Morristown, NJ 07960
Fax: 973-290-4182 Upload: https://www.cse.edu/student-life/health-services/secure-file-upload
Phone: 973-290-4132

For questions about nursing requirements and clinical clearance please contact nursing:
Professor Patricia Ricci-Allegra, (973) 290-4570 prallegra@cse.edu 2 Convent Road, Morristown, NJ 07960

- The Student is responsible for ensuring that all required FORMS ARE COMPLETED AND THE PHYSICIAN COMPLETES ALL MEDICAL INFORMATION.

- REQUIRED FORM A - HEALTH FORM
  - Identification Data
  - Emergency Information
  - Parental Endorsement for Medical Care (as indicated by age)
  - Personal and Family Medical History (reviewed/completed by your physician)
  - History and Physical must be within one year of entrance
  - Health care provider attestation

- REQUIRED FORM B - IMMUNIZATION RECORD and annual TB and flu compliance
  - Review requirements/completed 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 sign and submit the Meningitis information sheet.

- REQUIRED FORM D - AUTHORIZATION to Release Health Forms

To begin clinical rotations, you must receive a Health Clearance Form from the Nursing Program Chairperson.

Immunization Requirements –Start Immediately-Time Sensitive Requirements!
Where can you obtain an acceptable record of immunization?
Employee Health, High school, college, university, healthcare provider, family records.
Acceptable Records? The Record must show exact dates (month, day, year) and be signed by your Physician or health care provider.
DIRECTIONS:

- **History and Physical** must be **within one year of entrance**
- **MMR vaccine** 2 doses or 2 measles, 2 mumps, 2 rubella **AND/or evidence of immunity** - **REQUIRED**
  - First dose must be after the 1st birthday
  - Be aware! Between the two MMR doses a **minimum of 28 days** is required (single dose vaccines are not available)
  - **Copy of lab report** must be submitted as evidence of MMR immunity done within **5 years**
    - Equivocal titers are considered negative, **DO NOT ASSUME PRESENT IMMUNITY**
- **Hepatitis B vaccine** –2 or 3 dose series **AND or evidence of immunity** **REQUIRED**
  - **Copy of lab report** required as evidence of immunity. If positive disease - medical clearance.
  - Minimum of **4 weeks between doses 1 and 2**
  - Minimum of **8 weeks between doses 2 and 3**
  - Minimum of **16 weeks between doses 1 and 3** (for three dose series)
- **Hepatitis C Screening Required.** Copy of lab report. If **POSITIVE**, medical clearance is required.
- **Tdap (one dose)** Tdap or Td vaccine within 10 years **REQUIRED**
  - Primary series completed
- **Polio vaccine** **REQUIRED.**
  - Primary series completed or Positive Titer
  - A copy of the Lab report as evidence of immunity.
- **Varicella vaccine** 2 doses and/or documented history of disease - **REQUIRED**
  - **AND Copy of lab report** as evidence for immunity **REQUIRED**
- **Meningococcal vaccine (serogroup ACWY)**
  - Students less than 22 years old and all on-campus residents – **REQUIRED**
  - Final dose must be administered at or after the age of 16 years AND within 5 years of entry
- **Meningitis serogroup B vaccine** – **for age < 23**
- **Meningitis Information Sheet - Form C** **REQUIRED**
  - REMINDER: All students must confirm that they have received and read the information about Meningitis and the vaccines by signing the Meningitis Information Sheet (Form C).

**ANNUALLY**

- **Influenza VACCINE:** Annually.
- **TB Screening:**
  - IGRA-Interferon-gamma release assay or PPD /Mantoux testing – required within **SIX MONTHS** of entry. **Result must be in mm of induration for the PPD. A COPY of the Lab Report must be submitted to demonstrate evidence of screening.**
- **Recommended and Optional Vaccines**
  - HPV, Hib, Hepatitis A, Pneumococcal, Zoster, Typhoid, Yellow Fever. These vaccines are not required but to promote preventive health care and management they should be discussed with your physician.
PSYCHOLOGICAL AND DISABILITY SERVICES

If you require disability accommodations, you must self-identify and provide appropriate documentation directly to Lisa Seneca, Accessibility Services Coordinator, at 973-290-4261 or lseneca@cse.edu.

Accessibility Services
College of Saint Elizabeth
Mahoney Library
2 Convent Road
Morristown, New Jersey 07960

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: Zsuzsa Nagy, LCSW, Director of Counseling Services, at 973-290-4134 or znagy@cse.edu.

Counseling Services
College of Saint Elizabeth
Founders Hall
2 Convent Road
Morristown, New Jersey 07960

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.

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

COMPLETED RECORDS MUST BE RECEIVED BY June 1st

Send Records by mail, fax or upload

Health Services, College of Saint Elizabeth, Founders Hall, 2 Convent Road, Morristown, NJ 07960
Fax: 973-290-4182 Phone: 973-290-4132 upload https://www.cse.edu/student-life/health-services/secure-file-upload
Email: immunization@cse.edu

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Professor Patricia Ricci-Allegra
Nursing
(973) 290-4570
prallegra@cse.edu

Nursing Program, Immunizations, College of Saint Elizabeth, 2 Convent Road, Morristown NJ 07960
**REQUIRED FORM A – HEALTH FORM 5 PAGES A (1-5)**

**NURSING STUDENTS**

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

---

**IDENTIFICATION DATA A (1)**

Name __________________________________________________________________________

Last /Maiden name First Middle Date of Birth

Home Address ________________________________________________________________________

Street City State

Zip Code________ State/Country of Origin______________Telephone ______________________

email____________@__cell

Program/Degree___________Credits#______First Semester Enrolled ___/___ Expected Graduation Date ___/___

M/Y M/Y

Freshman _____ Transfer _____CSE Leave of Absence ___/___ CSE Withdrawal ___/___CSE Dismissal ___/___

M/Y M/Y

---

**HEALTH INSURANCE COVERAGE** - Please include a copy of your insurance card front and back.

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Address</th>
<th>Group and Policy#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber’s Name</th>
<th>Subscriber’s DOB</th>
<th>Subscriber’s SS #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**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.# ____________________________

---

**PARENTAL ENDORSEMENT FOR MEDICAL CARE**

Permission for medical care of minors (A parent’s or guardian’s signature is required)

For students under the age of 18: I hereby give permission to the medical and psychological staff of College of Saint. Elizabeth Health Services to examine and treat my minor child for all medical problems and injuries that may occur while he or she is at the College of Saint. Elizabeth.

DATE:  _________SIGNATURE:  ________________________RELATIONSHIP:_________________

---

**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></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<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></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health History Questionnaire: A (2)

<table>
<thead>
<tr>
<th>ALLERGY</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any significant allergy to food, medications, insects, pollen?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>List known allergies and type of reaction to them:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication:</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Food:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you take any medications regularly, including herbas, supplements and over the counter drugs?</td>
</tr>
<tr>
<td>Medications: List all medications and dosage that you take regularly prescription and non prescription (ex. Anxiety, ADD, depression, birth control, asthma, diabetes etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAST ILLNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis, mononucleosis, childhood diseases,</td>
</tr>
<tr>
<td>HIV</td>
</tr>
<tr>
<td>Loss or absence of any body parts.</td>
</tr>
<tr>
<td>Severe/frequent colds or flu</td>
</tr>
<tr>
<td>Serious illness or injury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any problems with your eyes, ears, nose or throat?</td>
</tr>
<tr>
<td>Hearing impairment</td>
</tr>
<tr>
<td>Loss of eye or eyesight</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CARDIOVASCULAR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart murmur/ palpitations</td>
</tr>
<tr>
<td>Chest pain</td>
</tr>
<tr>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>High blood pressure</td>
</tr>
<tr>
<td>Irregular heartbeat</td>
</tr>
<tr>
<td>Blood clots (not menstrual clots)</td>
</tr>
<tr>
<td>Enlarged heart</td>
</tr>
<tr>
<td>Mitral valve prolapse</td>
</tr>
<tr>
<td>Fainting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPIRATORY:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest infection (pneumonia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you smoke cigarettes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SKIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any problems with your skin?</td>
</tr>
<tr>
<td>Skin rashes</td>
</tr>
<tr>
<td>Acne</td>
</tr>
<tr>
<td>Eczema</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENDOCRINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>URINARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired function of any part of your urinary tract</td>
</tr>
<tr>
<td>Loss of a kidney</td>
</tr>
<tr>
<td>Recurrent urinary infection</td>
</tr>
<tr>
<td>Kidney Infection</td>
</tr>
<tr>
<td>Kidney stones</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>DRUG AND ALCOHOL USAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever felt you should cut down on your drinking?</td>
</tr>
<tr>
<td>Have people annoyed you by criticizing your drinking?</td>
</tr>
<tr>
<td>Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover?</td>
</tr>
<tr>
<td>Smoke cigarettes?</td>
</tr>
<tr>
<td>Please give specific information about drug usage (ex. Marijuana, pain medication, ecstasy)</td>
</tr>
</tbody>
</table>
A (3) Name: ____________________ DOB ____________________

**BLOOD:**
- Anemia: Yes [ ] No [ ]
- Sickle-cell disease/trait: Yes [ ] No [ ]
- Abnormal bleeding or bruising: Yes [ ] No [ ]

**BONE AND JOINT**
- Any serious disability, deformity or disease of bone, joint, or muscle: Yes [ ] No [ ]
- Injury, neck, shoulder, back, knee, ankle, other: Yes [ ] No [ ]
- Arthritis: Yes [ ] No [ ]

**NEUROLOGY**
- Concussion/head injury: Yes [ ] No [ ]
- Seizures or convulsions: Yes [ ] No [ ]
- Fainting or blackouts: Yes [ ] No [ ]
- Dizziness: Yes [ ] No [ ]
- Recurrent headaches: Yes [ ] No [ ]
- Migraines: Yes [ ] No [ ]

**GASTROINTESTINAL**
- Problems with any part of your intestinal tract or stomach: Yes [ ] No [ ]
- Jaundice/hepatitis/gallbladder disease: Yes [ ] No [ ]
- Hernia: Yes [ ] No [ ]
- Ulcer: Yes [ ] No [ ]
- Acid reflux: Yes [ ] No [ ]
- Irritable bowel syndrome: Yes [ ] No [ ]
- Inflammatory bowel disease: Yes [ ] No [ ]

**HEALTH AND NUTRITION**
- Are you following a special diet? Yes [ ] No [ ]
- Do you have an eating disorder? Yes [ ] No [ ]
- Unexplained weight loss / gain? Yes [ ] No [ ]

**REPRODUCTIVE SYSTEM (men):**
- Prostate trouble: Yes [ ] No [ ]
- Swelling of the scrotum or testicle: Yes [ ] No [ ]
- Undescended or absent testicle: Yes [ ] No [ ]
- Do you perform testicular self-examination? Yes [ ] No [ ]
- History of sexually transmitted disease: Yes [ ] No [ ]

**REPRODUCTIVE SYSTEM (women):**
- Never had a menstrual period? Yes [ ] No [ ]
- Any form of menstrual disorder? Yes [ ] No [ ]
- Do you perform breast self-exam? Yes [ ] No [ ]
- Last menstrual period: [ ]
- Abnormal PAP: Yes [ ] No [ ]
- History of sexually transmitted disease: Yes [ ] No [ ]
- History of pregnancy?: Yes [ ] No [ ]

**ACCIDENT PREVENTION**
- Do you usually wear a seat belt when you ride in car? Yes [ ] No [ ]
- Do you wear protective equipment when participating in a sports act? Yes [ ] No [ ]
- Do you drink and drive? Yes [ ] No [ ]

**Additional Explanations:**
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

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

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/PA/NP: Signature: __________________________ Date: _____ / _____ / _____

NURSING Form A– HISTORY & PHYSICAL must be reviewed by the physician 2019
Page 3 of 4
Physical Examination A (4)

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 College

| Patient Name _________________________________ Date of Birth ____________ | DATE OF EXAM __ / __ |
|----------------------------------------------------------------------------------|

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

**Hearing:** normal ☐ Yes ☐ No Abnormal__________ Color Vision ☐ normal ☐ abnormal______________

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

**System** | **Satisfactory** | **Describe Abnormality**
--- | --- | ---
Eyes |  |  |
Ears |  |  |
Nose, throat |  |  |
Neck, thyroid |  |  |
Chest, lungs |  |  |
Breast |  |  |
Heart |  |  |
Abdomen, liver, kidneys, spleen |  |  |
Lymphatic’s |  |  |
Hernia |  |  |
Genitalia |  |  |
Pelvic (if indicated) |  |  |
Rectal |  |  |
Extremities, back, spine |  |  |
Skin |  |  |
Joints |  |  |
Neurological |  |  |
Psychological |  |  |

**Laboratory Tests:** URINALYSIS ____________________________
BLOOD Cholesterol (Fasting) _______ CBC _______ Sickle Cell Screening and EKG for Athletes _________
Additional labs as indicated ___________________________________________________________

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

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Applicant may participate in all College activities: including sports, physical education and intramurals, nursing activities and responsibilities
☐ Without restriction
☐ With the following restrictions and reason: ______________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

**History Reviewed & Student Examined by:**
Physician name (print): ____________________________________ Date _________________
Signature/Stamp ___________________________________________
Address ___________________________________________________________________________
Phone __________________ Fax ________________

NURSING Form A– HISTORY & PHYSICAL must be reviewed by the physician 2019
Page 4 of 4
Healthcare Provider Attestation  FORM A (5)

Part A: To be completed by Student

Name ___________________________________________  ________/_____/_________  
Last/Maiden Name  First  Middle  Date of Birth (mm/dd/yyyy)

Home Address __________________________________________
Street  City  State  Zip Code

State/Country of Origin _____________________________

Email _____________________________________________

Cell Phone ___________________________  Home Phone ________________

Part B: To be completed by Healthcare Provider

Attestation:
I have reviewed the immunization record, tuberculosis screening results, and Health History Questionnaire, and examined the above student on (date) ___/_____/______. The student is in good health, is free from evidence of communicable disease and does not pose a health risk to students or employees at the College of Saint Elizabeth or to patients and employees of the clinical agencies utilized during clinical rotations.

____________________________________________  ______________________
Signature  Date

____________________________________________
Print Name

____________________________________________
Street Address  City  State

____________________________________________
Phone Number  Fax

Office Stamp:
## IMMUNIZATION RECORD NURSING B(1)

**REQUIRED VACCINES** - read all instruction documents carefully

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>College of St. Elizabeth and NJ State Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td>2 doses AND / or</td>
</tr>
<tr>
<td></td>
<td>1st dose given after 1st birthday</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimum of 4 weeks between doses</td>
<td></td>
</tr>
<tr>
<td>AND positive immune titers</td>
<td>#1 ___ / ___ / ___ #2 <em><strong>/</strong></em>/___</td>
<td>Positive titers within 5 years</td>
</tr>
<tr>
<td>Measles</td>
<td>AND/OR Positive Titer Date: <em><strong>/</strong></em>/___ Required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>copy of lab report within 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1 ___ / ___ / ___ #2 <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AND/OR Positive Titer Date: <em><strong>/</strong></em>/___ Required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>copy of lab report within 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1 ___ / ___ / ___ #2 <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AND/OR Positive Titer Date: <em><strong>/</strong></em>/___ Required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>copy of lab report within 5 years</td>
<td></td>
</tr>
<tr>
<td>Mumps</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 sign and submit</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trumemba □ Bersero</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Required for students ≤ 23 years of Age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As recommended by the CDC</td>
<td></td>
</tr>
<tr>
<td>Vaccination ACWY</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td>All &lt; 22 years and all college residents.</td>
</tr>
<tr>
<td>Serogroup B</td>
<td>□ Menomune □ Menactra □ Menevo</td>
<td>Final dose must be at or after the age of 16 years old</td>
</tr>
<tr>
<td></td>
<td>□ Meningitis information sheet sign and submit</td>
<td>AND within five years of entry</td>
</tr>
<tr>
<td></td>
<td>Required for students &lt; 23 years of Age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As recommended by the CDC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completed Primary series</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tdap <em><strong>/</strong></em>/___ Td <em><strong>/</strong></em>/___</td>
<td>Tdap 1 dose</td>
</tr>
<tr>
<td></td>
<td>DTP DT <em><strong>/</strong></em>/___</td>
<td>Tdap or Td within 10 years</td>
</tr>
<tr>
<td>Polio</td>
<td>Primary series: □ Oral □ Injectable</td>
<td>Completed Primary series or Positive Titer</td>
</tr>
<tr>
<td></td>
<td>Most recent booster : <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td>2 doses varicella vaccine or history of disease AND positive titer</td>
</tr>
<tr>
<td>(Chicken Pox)</td>
<td>AND/OR Positive Titer Date: <em><strong>/</strong></em>/___ Required</td>
<td>Minimum of 4 weeks between doses if age &gt; 13</td>
</tr>
<tr>
<td></td>
<td>copy of lab report</td>
<td></td>
</tr>
</tbody>
</table>

**Signature Health Care Provider**

Name ___________________________ DOB ___________________________
### Interferon-gamma release assay tests (IGRA)

- Interferon-gamma release assay tests (IGRA) __/__/___  
  - pos.  
  - neg. copy of report
- 1) PPD __/__/___  
  - Read  
  - Plant
- 2) PPD __/__/___  
  - Read  
  - Plant

### Flu Vaccine

- Flu Vaccine
  - Annual Date __/__/__  
  - __/__/__  
  - __/__/__

### Recommended & Optional Vaccines

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV</td>
<td>#1 <strong>/</strong>/__  #2 <strong>/</strong>/__  #3 <strong>/</strong>/__</td>
<td>As per the CDC</td>
</tr>
<tr>
<td>Hib</td>
<td><strong>/</strong>/__</td>
<td>Primary series completed</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>#1 <strong>/</strong>/__  #2 <strong>/</strong>/__</td>
<td>As per the CDC 6-12 months between doses 1 and 2</td>
</tr>
</tbody>
</table>
| Pneumococcal        | #1 __/__/__  #2 __/__/__  
  - Polysaccharide (PPV)  
  - Conjugate (PCV)13  
  - PPSV 23          | As per the CDC                                      |
| Zoster              | #1 __/__/__          | As per the CDC                                      |
| Typhoid             | #1 __/__/__          | Travel                                              |
| Yellow Fever        | #1 __/__/__          | Travel                                              |
| Shingles            | #1 __/__/__  #2 __/__/__  
  - Shingrix,  
  - Zostavax.     | 2-6 months between doses 1 and 2  
  - As per the CDC                                        |

**Student Name: ___________________________ DOB __/__/____

**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></td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Send Health Immunization Records by mail, upload or fax
College of Saint Elizabeth, Health Service, Founders Hall, 2 Convent Road, Morristown, N.J., 07960  
Fax: 973 290 4182  
Phone 973 290 4175, 4132
Upload: [https://www.cse.edu/student-life/health-services/secure-file-upload](https://www.cse.edu/student-life/health-services/secure-file-upload)

For questions about nursing requirements and clinical clearance please contact nursing:
Professor Patricia Ricci-Allegra  
(973) 290-4570  
prallegra@cse.edu
Nursing, College of St. Elizabeth, 2 Convent Road, Morristown, NJ 07960
REQUIRED FORM C: MENINGITIS INFORMATION SHEET
REQURED 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 College of Saint Elizabeth, all college 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 St. 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 ACYW) 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.cse.edu/student-life/health-services/secure-file-upload

College of Saint Elizabeth
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@cse.edu

GRADUATE & CONTINUING STUDIES – MENINGITIS INFORMATION SHEET REQUIRED FORM #3
Updated June 2019
Required Form – D

Authorization to release information to the CSE Nursing Program

Name ______________________________________________________________________
Last /Maiden Name First Middle _______ / _______ _______
Date of Birth (mm/dd/yyyy)

Home Address _________________________________________________________________________________
Street City State Zip Code

State/Country of Origin __________ Telephone ____________________________

Email: ___________________________________________ Cell: __________________ Home: _________________

By signing below, I am authorizing the release of my health and immunization records and results of my tuberculosis screening and tests results as documented in health forms as well as the Healthcare Provider Attestation Statement to the Nursing Program in order to maintain a copy in my student record.

I am furthermore authorizing the Nursing Program to release those records to all clinical sites to which I am assigned for my supervised clinical practice experiences.

Please forward a copy of my Health and Immunization records, TB Screening, Testing and Healthcare provider Attestation forms records to:

College of Saint Elizabeth
Nursing Program
2 Convent Road
Morristown, NJ 07960
Attention: Health and Immunizations
Professor Patricia Ricci-Allegra

Print Name: _________________________________________________________________________________

Signature ___________________________________________________________________________ Date ________________

Questions/Concerns please call Nursing (973) 290-4570 prallegra@cse.edu
AUTHORIZATION TO RELEASE MEDICAL AND IMMUNIZATION RECORDS TO THE
COLLEGE OF SAINT ELIZABETH HEALTH SERVICES

Date  __________

Student Name ________________________________________________________________

Date of Birth ___/___/_______

Address _________________________________________________________________

City __________ State ___________ ZIP Code ___________

Phone Number _____ - _____ - _________ Student ID _____________

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

____________________________________________________________________________

to release (check all those that are indicated)

☐ Immunization Records   ☐ Medical Records

Please forward my records to:

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

If you wish, you may fax the information to (973) 290-4182 or
upload: https://www.cse.edu/student-life/health-services/secure-file-upload

Questions/Concerns please call (973) 290-4132 or 4175.

Signature _____________________________________________ Date ________________

Name of Parent or Guardian (if under 18) _______________________________________

Please print

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

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

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

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 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

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
- 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.

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.

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- Contact the Centers for Disease Control and Prevention (CDC):
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  - Visit CDC’s www.cdc.gov/vaccines