REQUIRED FORMS CHECKLIST

Please read and follow all instructions carefully for each form.

Note: New Jersey State Law, the College of Saint Elizabeth and the Physician Assistant Program requires documentation of immunizations to be on file with the Office of Student Health Services prior to the first day of class. All additional medical forms as outlined below are also due prior to the start of classes. Therefore, ALL FORMS ARE DUE NO LATER THAN AUGUST 1ST for the Physician Assistant Program. Non-Compliance will result in a $350 fee and/or registration hold.

☐ REQUIRED FORM A - HEALTH FORMS (6 pages)
- Release of Medical and Immunization to CSE Office of Health Services – pg. 1
  Note: This form authorizes your medical provider to release information to the Office of Health Services and should not be confused with Required Form-D listed below. Required Form-D authorizes the Office of Student Health Services to release your Immunization and TB Screenings to the Physician Assistant Program as required for Clinical Rotations
- Identification Data and Emergency Contacts - pg. 2
- Health Insurance and Healthcare providers – pg. 2
- Health History Questionnaire – pg. 3-4 (must be completed by student; reviewed and signed by healthcare provider)
- Physical Examination - pg. 5 (must be completed and signed by healthcare provider)
- Healthcare Provider Attestation – pg. 6 (Part A-completed by Student; Part B- complete by healthcare provider)
  Note(s): Physical Exam must be within six months of entrance

☐ REQUIRED FORM B - IMMUNIZATION RECORD
- Please see the Required Vaccination and TB screening Checklist
- Required form B must be completed and signed your physician or other healthcare provider

☐ REQUIRED FORM C - MENINGITIS INFORMATION SHEET
- All students must confirm that they have received and read the Information about meningitis and the vaccine by signing the Meningitis Information Sheet (Form C).

☐ REQUIRED FORM D
Release of Immunization and TB screenings to the Physician Assistant Program. (Please provide two copies of your Immunization and TB screenings) Note: This form authorizes the Office of Student Health Services to release your Immunization and TB Screenings to the Physician Assistant Program as required for Clinical Rotations.

Complete and send a copy of all Required forms to:
College of Saint Elizabeth
Office of Student Health Services
Founders Hall
2 Convent Road, Morristown, NJ 07960
Phone: 973-290-4132  Fax: 973-290-4182  PA Program Coordinator: 973-290-4154

*All students are required to update these records prior to the clinical phase of the PA Program.
REQUIRED VACCINATIONS & SCREENING CHECKLIST

You may be able to obtain acceptable immunization records from your current or previous healthcare provider, previous or current employers, high-schools, colleges, universities or other post-secondary institutions you may have attended or in your family records. Your immunization records must show exact vaccination dates (month, day, year) and must be signed by your physician or health care provider. Note: These immunization are based on the CDC, CSE requirements and the NJ State Law; clinical sites may have additional requirements.

VACCINATIONS

☐ MMR VACCINE: 2 doses of MMR OR 2 measles, 2 mumps, 2 rubella
   o First dose must be after the 1st birthday
   o A minimum of 28 days is required between the two MMR doses (single dose vaccines are not available)
   o Equivocal titers are considered negative
   o A copy of the lab report must also be submitted as evidence of MMR immunity. (Must be within the last 5 years. Do not assume immunity based on previous lab results.)

☐ HEPATITIS B VACCINE: 3 dose series AND/OR A copy of the lab report as evidence of immunity.
   o Minimum of 4 weeks between doses 1 and 2
   o Minimum of 8 weeks between doses 2 and 3
   o Minimum of 16 weeks between doses 1 and 3

☐ Tdap (ONE DOSE) Tdap OR Td VACCINE: Must be within the last 10 yrs. Record date for completed primary series

☐ POLIO VACCINE: Primary series completed OR Positive Titer
   o A copy of the lab report as evidence of immunity

☐ VARICELLA VACCINE: 2 doses OR documented history of disease
   o A copy of the lab report must be submitted as evidence of immunity.

☐ MENINGOCOCCAL VACCINE (Serogroup ACWY)
   o This is a Requirement for students less than or equal to 23 years old and all on-campus residents
   o 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 form C
   o Reminder: All students must confirm that they have received and read the Information about Meningitis and the vaccine by signing the Meningitis Information Sheet. (Form C)

☐ INFLUENZA VACCINE: Annually

TB SCREENING

☐ IGRA-Interferon-gamma release assay or two step PPD/Mantoux testing within six months of entry
   o Result must be in mm of induration for the PPD
   o A copy of the lab report must be submitted to demonstrate evidence of screening

Medical records are strictly confidential and are used exclusively by the Office of Student Health Services as required by Federal and State Law. Please Note: Immunization records and TB screenings are an exception and are not confidential. Your immunization records and TB screenings will be made available to the CSE PA Program with your authorization as per Required Form D.

PA Students - Instructions for Medical Forms
Updated May 2019
PSYCHOLOGICAL AND DISABILITY SERVICES

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

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.
Required Form - A

Authorization to Release Medical and Immunization Records
to the College of Saint Elizabeth Office of Student Health Services

(Note: This form authorizes your medical provider to release information to the CSE Office of Student Health Services and should not be confused with Required Form-D. Required Form-D authorizes the CSE Office of Student Health Services to release your Immunization and TB screenings to the CSE Physician Assistant Program as required for Clinical Rotations)

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

to Health Services at the College of Saint Elizabeth. 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.
Questions/Concerns please call (973) 290-4132 or 4175.

Signature ______________________________ Date _______________________

Relationship to patient ________________________________
Required Form – A

IDENTIFICATION DATA
Name ___________________________________________ Date of Birth (mm/dd/yyyy)

Last/Maiden name ________________________________ First ____________________________

Middle ___________________________ Middle ___________________________

Home Address ____________________________ State ______________ City ________________

Street ________________________________________ State ______________ Zip Code ____________

State/Country of Origin ___________________________ Telephone ___________________________

Email: ___________________________________________ Cell: ____________________________ Home: ____________________________

First Semester Enrolled ___/___ M/Y Expected Graduation Date ___/___ M/Y

Freshman ___ Transfer ___

CSE Leave Of Absence ___/___ M/Y CSE Withdrawal ___/___ M/Y CSE Dismissal ___/___ M/Y

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. # ____________________________

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 # ____________________________

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

Name/specialty

Address

City, State

Telephone

Fax

Name/specialty

Address

City, State

Telephone

Fax

Require Form A, Page 2
Required Form A - Health History Questionnaire
To be completed by student - reviewed and signed by physician/PA/NP

Name: 
Date of Birth: 

**Answer ALL questions Explain All YES Answers**

<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: 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>

**MEDICATIONS:**
Do you take any medications regularly, including herbs, 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)

---

Required Form A, Page 3
5/29/2019
Required Form A - Health History Questionnaire
To be completed by student - reviewed and signed by physician/PA/NP

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>BLOOD:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sickle-cell disease/trait</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Abnormal bleeding or bruising</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BONE AND JOINT</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any serious disability, deformity or disease of bone, joint, or muscle?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Injury, neck, shoulder, back, knee, ankle, other</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Arthritis</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEUROLOGY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concussion/head injury</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Seizures or convulsions</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Fainting or blackouts</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dizziness</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Recurrent headaches</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Migraines</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GASTROINTESTINAL</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with any part of your intestinal tract or stomach?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Jaundice/hepatitis/gallbladder disease</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hernia</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ulcer</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Acid reflux</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH AND NUTRITION</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you following a special diet?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you have an eating disorder?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Unexplained weight loss / gain?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPRODUCTIVE SYSTEM (men):</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate trouble</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Swelling of the scrotum or testicle</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Undescended or absent testicle</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you perform testicular self-examination?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>History of sexually transmitted disease</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPRODUCTIVE SYSTEM (women):</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never had a menstrual period?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Any form of menstrual disorder?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you perform breast self-exam?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Last menstrual period</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Abnormal PAP</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>History of sexually transmitted disease</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>History of pregnancy?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACCIDENT PREVENTION</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you usually wear a seat belt when you ride in car?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you wear protective equipment when participating in a sports act?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you drink and drive?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Additional Explanations:

---

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>
<tr>
<td>Migraine</td>
<td></td>
<td></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: ___________________________ Date: __/__/____

History Reviewed by Physician/PA/NP- Signature: ______________________ Date: __/__/____

Required Form A, Page 4
5/29/2019
Required Form – A
Physical Examination
Physical exam to be completed by the physician/PA/NP and performed within six months prior to entrance to the College

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>
</tr>
<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>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<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, as needed

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

Applicant may participate in College 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 __________________________________

Required Form A, Page 5
5/29/2019
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
Telephone

Email: ____________________________ Cell: ____________________________ Home: ____________________________

Part B: To be completed by Physician

Attestation:
I have reviewed the immunization record, tuberculosis screening results, and Health History Questionnaire, and examined the above named 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 partners of the PA Program.

<table>
<thead>
<tr>
<th>Healthcare Provider</th>
<th>Address/Stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Phone</td>
</tr>
<tr>
<td>Date</td>
<td>Fax</td>
</tr>
</tbody>
</table>
# REQUIRED FORM - B
# IMMUNIZATION RECORD & TB SCREENINGS

**Name:** ___________________________  **D.O.B.:** ___________________________  **Class (Year):** ___________________________

## REQUIRED VACCINATIONS

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>College of Saint Elizabeth and NJ State Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR OR Measles</td>
<td>#1 / /  #2 / /  OR  #1 / /  #2 / /</td>
<td>2 doses of MMR OR 2 measles, 2 mumps, 2 rubella</td>
</tr>
<tr>
<td></td>
<td>#1 / /  #2 / /</td>
<td>First dose must be after the 1st birthday</td>
</tr>
<tr>
<td>Mumps Rubella</td>
<td>#1 / /  #2 / /</td>
<td>A minimum of 28 days is required between the two MMR doses (single dose vaccines are not available)</td>
</tr>
<tr>
<td></td>
<td>#1 / /  #2 / /</td>
<td></td>
</tr>
</tbody>
</table>

**AND Measles**
- AND Positive Titer Date: / /  
- Required copy of lab report within 5 years

**Mumps**
- AND Positive Titer Date / /  
- Required copy of lab report within 5 years

**Rubella**
- AND Positive Titer Date: / /  
- Required copy of lab report within 5 years

**Hepatitis B**
- #1 / /  #2 / /  #3 / /  
- AND/OR Positive Titer Date: / /  
- Required copy of lab report
  - c: EnferosalB  c: Recombivax  c: Heplisav-B
- 3 dose series AND/OR A copy of the lab report must be submitted as evidence of immunity.

**Tdap Td**
- Tdap / /  Td / /  
- Tdap (1 dose)
- Tdap or Td within 10 years
- Completed primary series

**Polio**
- Primary series:  
  - Oral  
  - Injectable
- Most recent booster: / /  
- Completed Primary series or Positive Titer

**Varicella (Chicken Pox)**
- #1 / /  #2 / /  
- AND Positive Titer Date: / /  
- History of disease  
  - No  
  - Yes Date / /  
- 2 doses varicella vaccine or history of disease and positive titer
- Minimum of 4 weeks between doses if age 13 or older

**Meningitis Serogroup ACWY**
- #1 / /  #2 / /  
- Menomune  Menactra  Menceo
- This is a Requirement for students less than or equal to 23 years old and all on-campus residents
- Final dose must be administered at or after the age of 16 years AND within 5 years of entry

**Information Sheet**
- Meningitis information sheet sign and submit

**Meningitis Serogroup B**
- #1 / /  #2 / /  #3 / /  
- Trumenba  Bexsero
- Required for all students ≤ 23 years of age

---

**Signature Health Care Provider** ___________________________  **Print Name** ___________________________  **Date** ___________________________
**REQUIRED TB SCREENINGS**

<table>
<thead>
<tr>
<th>Influenza</th>
<th>Within one year with Yearly update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interferon-gamma release assay tests (IGRA)</td>
<td>Result must be in \textit{mm of induration for the PPD}</td>
</tr>
<tr>
<td>1) PPD Planted / / Read / / result mm</td>
<td>A copy of the lab report must be submitted to demonstrate evidence of immunity</td>
</tr>
<tr>
<td>2) PPD Planted / / Read / / result mm</td>
<td></td>
</tr>
<tr>
<td>Positive PPD in past BCG history / / /</td>
<td></td>
</tr>
<tr>
<td>If PPD or Interferon-gamma release assay tests (IGRA) is positive, chest x-ray is required: chest x-ray / / /</td>
<td></td>
</tr>
<tr>
<td>INH treatment began / / completed / /</td>
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</tr>
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**RECOMMENDED VACCINATIONS**

Note: The following vaccinations are \textit{recommended} by the CSE Office of Student Health Services, but are \textbf{NOT} required by the Physician Assistant program.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>#1 / / / #2 / / / Recommended if planning to travel and high risk exposure</td>
</tr>
<tr>
<td></td>
<td>6-12 months between doses 1 and 2</td>
</tr>
<tr>
<td><strong>Pneumococcal</strong></td>
<td>#1 / / / Polysaccharide (PPV) Conjugate (PCV)13 PPSV 23 Chronic health problems</td>
</tr>
<tr>
<td><strong>HPV</strong></td>
<td>#1 / / / #2 / / / #3 / / / Gardasil Cervarix Gardasil9 Strong recommendation-preventative health care</td>
</tr>
<tr>
<td><strong>Hib</strong></td>
<td>/ / / Primary Series Completed</td>
</tr>
</tbody>
</table>

**HEALTH CARE PROVIDER**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print Name</th>
<th>Date</th>
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Address | City | State | Zip |
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Telephone | Fax |
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</table>

\textit{Send Records by mail or fax a copy to:}

College of Saint Elizabeth
Office of Student Health Services
Founders Hall
2 Convent Road, Morristown, NJ 07960

\textbf{Phone: 973-290-4132} \textbf{Fax: 973-290-4182} \textbf{PA Program Phone: 973-290-4154}
VACCINE INFORMATION STATEMENT

Serogroup B Meningococcal Vaccine (MenB): What You Need to Know

1 Why get vaccinated?

Meningococcal disease is a serious illness caused by a type of bacteria called Neisseria meningitidis. It can lead to meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Meningococcal disease often occurs without warning—even among people who are otherwise healthy.

Meningococcal disease can spread from person to person through close contact (coughing or kissing) or lengthy contact, especially among people living in the same household.

There are at least 12 types of N. meningitidis, called “serogroups.” Serogroups A, B, C, W, and Y cause most meningococcal disease.

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
- People at risk because of an outbreak in their community

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, amputations, nervous system problems, or severe scars from skin grafts.

Serogroup B meningococcal (MenB) vaccines can help prevent meningococcal disease caused by serogroup B. Other meningococcal vaccines are recommended to help protect against serogroups A, C, W, and Y.

These vaccines are recommended routinely for people 10 years or older who are at increased risk for serogroup B meningococcal infections, including:
- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed
- Anyone with a rare immune system condition called “persistent complement component deficiency”
- Anyone taking a drug called eculizumab (also called Soliris®)
- 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. For best protection, more than 1 dose of a serogroup B meningococcal vaccine is needed. The same vaccine must be used for all doses. Ask your health care provider about the number and timing of doses.

2 Serogroup B Meningococcal Vaccines

Two serogroup B meningococcal vaccines—Bexsero® and Trumenba®—have been licensed by the Food and Drug Administration (FDA).

3 Some people should not get these vaccines

Tell the person who is giving you the vaccine:

- If you have any severe, life-threatening allergies. If you have ever had a life-threatening allergic reaction after a previous dose of serogroup B meningococcal vaccine, or if you have a severe allergy to any part of this vaccine, you should not get the vaccine. Tell your health care provider if you have any severe allergies that you know of, including a severe allergy to latex. He or she can tell you about the vaccine’s ingredients.

- If you are pregnant or breastfeeding. There is not very much information about the potential risks of this vaccine for a pregnant woman or breastfeeding mother. It should be used during pregnancy only if clearly needed.

If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.
4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own within a few days, but serious reactions are also possible.

More than half of the people who get serogroup B meningococcal vaccine have mild problems following vaccination. These reactions can last up to 3 to 7 days, and include:

- Soreness, redness, or swelling where the shot was given
- Tiredness or fatigue
- Headache
- Muscle or joint pain
- Fever or chills
- Nausea or diarrhea

Other problems that could happen after these vaccines:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.

- Some people get shoulder pain that can be more severe and longer-lasting than the more routine soreness that can follow injections. This happens very rarely.

- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

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

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 and get to the nearest hospital. Otherwise, call your clinic.

Afterward the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does 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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider. He or she can give you the vaccine package insert or suggest other sources of information.
- 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 website at www.cdc.gov/vaccines

Vaccine Information Statement
Serogroup B Meningococcal Vaccine

08/09/2016
42 U.S.C. § 300aa-26
Meningococcal ACWY Vaccine: What You Need to Know

1 Why get vaccinated?

Meningococcal disease is a serious illness caused by a type of bacteria called Neisseria meningitidis. It can lead to meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Meningococcal disease often occurs without warning—even among people who are otherwise healthy.

Meningococcal disease can spread from person to person through close contact (coughing or kissing) or lengthy contact, especially among people living in the same household.

There are at least 12 types of N. meningitidis, called “serogroups.” Serogroups A, B, C, W, and Y cause most meningococcal disease.

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
- People at risk because of an outbreak in their community

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, amputations, nervous system problems, or severe scars from skin grafts.

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

2 Meningococcal ACWY Vaccine

Meningococcal conjugate vaccine (MenACWY) is licensed by the Food and Drug Administration (FDA) for protection against serogroups A, C, W, and Y.

Two doses of MenACWY are routinely recommended for adolescents 11 through 18 years old: the first dose at 11 or 12 years old, with a booster dose at age 16. Some adolescents, including those with HIV, should get additional doses. Ask your health care provider for more information.

In addition to routine vaccination for adolescents, MenACWY 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 drug called eculizumab (also called Soliris®)
- 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 dormitories
- U.S. military recruits

Some people need multiple doses for adequate protection. Ask your health care provider about the number and timing of doses, and the need for booster doses.
Some people should not get this vaccine

Tell the person who is giving you the vaccine if you have any severe, life-threatening allergies. If you have ever had a life-threatening allergic reaction after a previous dose of meningococcal ACWY vaccine, or if you have a severe allergy to any part of this vaccine, you should not get this vaccine. Your provider can tell you about the vaccine’s ingredients.

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 MenACWY vaccination. A pregnant or breastfeeding woman should be vaccinated if she is at increased risk of meningococcal disease.

If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own within a few days, but serious reactions are also possible.

As many as half of the people who get meningococcal ACWY vaccine have mild problems following vaccination, such as redness or soreness where the shot was given. If these problems occur, they usually last for 1 or 2 days.

A small percentage of people who receive the vaccine experience muscle or joint pains.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy or lightheaded, or have vision changes.

- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.

- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

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

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What should I do?

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Afterward, the reaction should be reported to the “Vaccine Adverse Event Reporting System” (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

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How can I learn more?

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- 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 website at www.cdc.gov/vaccines
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 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 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 “Sernogroup 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 this required form to:
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

TRADITIONAL UNDERGRADUATE STUDENTS – MENINGITIS INFORMATION SHEET REQUIRED FORM #3
Updated April 2016
Required Form – D

Authorization to release information to the CSE Physician Assistant Program

Name ___________________________ First _______ Middle _______ Date of Birth (mm/dd/yyyy) _______ _______ _______

Last/Maiden Name

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 immunization records and results of my tuberculosis screening as documented in required Form B as well as the Healthcare Provider Attestation Statement (Form A, page 5) to the Physician Assistant Program in order to maintain a copy in my student record.

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

I understand that no other medical records will be provided to Physician Assistant Program or the clinical site without my express authorization.

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

College of Saint Elizabeth
Physician Assistant program
2 Convent Road
Morristown, NJ 07960
Attention: Kim Booth, Program Coordinator

Print Name: ___________________________________________

Signature ___________________________________________ Date ___________________________

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

AUTHORIZATION TO RELEASE MEDICAL & IMMUNIZATION RECORDS