REQUIRED FORMS CHECKLIST
Please read and follow all instructions carefully for each form.

Note: New Jersey State Law, Saint Elizabeth University and the SEU Physician Assistant Program (SEU PA Program) requires documentation of immunizations and other medical requirements to be on file with both, the Office of Student Health Services and the SEU PA Program prior to the first day of class.

ALL FORMS ARE DUE NO LATER THAN JULY 1, 2021
Non-Compliance will result in a $350 fee and/or registration hold.

Please complete and upload to: https://www.steu.edu/meduploads

- **REQUIRED FORM A - HEALTH FORM (6 pages)**
  - Release of Medical and Immunization to SEU Office of Health Services – pg. 1
  - 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- completed 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 https://www.steu.edu/student-life/health-services/meningitis by signing the Meningitis Information Sheet (Form C).

- **REQUIRED FORM D**
  - Release of Immunization and TB screenings Physician Assistant Program. 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 UPLOAD TO: https://www.steu.edu/meduploads

OR MAIL TO:
Saint Elizabeth University; Office of Student Health Services; Founders Hall, 2 Convent Road, Morristown, NJ 07960

OR FAX TO: 973-290-4182

Immunization Information Line: 973-290-4388 ext 4388; or Immunization@st.eu
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 requirements are based on the CDC and the NJ State Law; clinical sites may have additional requirements. Note: Medical records are strictly confidential and are used exclusively by the Office of Student Health Services as required by Federal and State Law Immunization records and TB screenings are an exception. Your Immunization records and TB screenings will be made available to the SEU PA Program with your authorization as per Required Form D.

VACCINATIONS

- **MMR VACCINE**: 2 doses of MMR OR 2 measles, 2 mumps, 2 rubella
  - First dose must be after the 1st birthday
  - A minimum of 28 days is required between the two MMR doses (single dose vaccines are not available)
  - Equivocal titers are considered negative
  - 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.
  - 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

- **TDAP (ONE DOSE) TDAP OR TD VACCINE**: Primary series completed (Must be within the last 10 yrs.)

- **POLIO VACCINE**: Primary series completed OR Positive Titer
  - A copy of the lab report as evidence of immunity.

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

- **MENINGOCOCCAL VACCINE** (Serogroup ACWY)
  - 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

- **MENINGITIS SEROGROUP B VACCINE – FOR AGE ≤ 23**
  - Meningitis Information form C
  - 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

- **COVID-19 VACCINE** (As per CDC and ACIP)

TB SCREENING

- **IGRA-Interferon-gamma release assay or two step PPD /Mantoux testing** 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
PSYCHOLOGICAL AND DISABILITY SERVICES

The health form 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 other Saint Elizabeth University 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 iseneca@steu.edu.

Accessibility Services
Saint Elizabeth University
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@steu.edu.

Counseling Services
Saint Elizabeth University
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 Saint Elizabeth University Office of Student Health Services

(Note: This form authorizes your medical provider to release information to the SEU Office of Student Health Services and should not be confused with Required Form-D. Required Form-D authorizes the SEU Office of Student Health Services to release your Immunization and TB screenings to the SEU 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 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 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

Home Address ____________________________________________

Street City State Zip Code

State/Country of Origin Telephone _________________________________

Email: ________________________________________ Cell: ____________________ Home: ______________________

First Semester Enrolled ____/____ Expected Graduation Date ____/____ Freshman ____ Transfer ____

M/Y M/Y

SEU Leave Of Absence ____/____ SEU Withdrawal ____/____ SEU Dismissal ____/____

M/Y M/Y 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

<table>
<thead>
<tr>
<th>Name/specialty</th>
<th>Address</th>
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<th></th>
<th>City, State</th>
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<tbody>
<tr>
<td>PhoneNumber</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
</tbody>
</table>
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? □  □
  - 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
07/01/2021
Required Form A - Health History Questionnaire
To be completed by student - reviewed and signed by physician/PA/NP

Name: __________________________________________

BLOOD: Yes No
Anemia ☐ ☐
Sickle-cell disease/trait ☐ ☐
Abnormal bleeding or bruising ☐ ☐

BONE AND JOINT
Any serious disability, deformity or disease of bone, joint, or muscle? ☐ ☐
Injury, neck, shoulder, back, knee, ankle, other ☐ ☐
Arthritis ☐ ☐

NEUROLOGY
Concussion/head injury ☐ ☐
Seizures or convulsions ☐ ☐
Fainting or blackouts ☐ ☐
Dizziness ☐ ☐
Recurrent headaches ☐ ☐
Migraines ☐ ☐

GASTROINTESTINAL
Problems with any part of your intestinal tract or stomach? ☐ ☐
Jaundice/hepatitis/gallbladder disease ☐ ☐
Hernia ☐ ☐
Ulcer ☐ ☐
Acid reflex ☐ ☐
Irritable bowel syndrome ☐ ☐
Inflammatory bowel disease ☐ ☐

Health and Nutrition
Are you following a special diet? ☐ ☐
Do you have an eating disorder? ☐ ☐
Unexplained weight loss / gain? ☐ ☐

Reproductive System (men):
Prostate trouble ☐ ☐
Swelling of the scrotum or testicle ☐ ☐
Undescended or absent testicle ☐ ☐
Do you perform testicular self-examination? ☐ ☐
History of sexually transmitted disease ☐ ☐

Reproductive System (women):
Never had a menstrual period? ☐ ☐
Any form of menstrual disorder? ☐ ☐
Do you perform breast self-exam? ☐ ☐
Last menstrual period __________
Abnormal PAP ☐ ☐
History of sexually transmitted disease ☐ ☐
History of pregnancy? ☐ ☐

Accident Prevention
Do you usually wear a seat belt when you ride in car? ☐ ☐
Do you wear protective equipment when participating in a sports act? ☐ ☐
Do you drink and drive? ☐ ☐

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)

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

Required Form A, Page 4
07/01/2021
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 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>
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</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
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<tr>
<td>Psychological</td>
<td></td>
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</tr>
</tbody>
</table>

Laboratory Tests: if 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 University activities:

☐ Without Restriction
☐ With the following restrictions and reason: ____________________________________________

History Reviewed & Student Examined by:

Physician / PA / NP name (print): ___________________________ Date _______________________

Signature/stamp __________________________________________

Required Form A, Page 5
07/01/2021
Required Form – A
Healthcare Provider Attestation

Part A: To be completed by Student

Name ____________________________________________________________ Date of Birth (mm/dd/yyyy) _____ / _____ / ______

Last /Maiden Name First Middle

Home Address _______________________________________________________

Street City State Zip Code

State/Country of Origin Telephone ____________________________

Email: ____________________________ Cell: ____________________________ Home: ____________________________

Part B: To be completed by Physician/Healthcare Provider

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 Saint Elizabeth University or to patients and employees of the clinical partners of the PA Program.

Healthcare Provider Address/Stamp

Print Name

Signature

Date

Phone

Fax

Required Form A, Page 6
07/01/2021
# REQUIRED VACCINATIONS

**Vaccines** | **Dates Given** | **Saint Elizabeth University and NJ State Requirements**
---|---|---
**MMR OR Measles Mumps Rubella**<br> #1 / / / #2 / / /<br> OR<br> #1 / / / #2 / / /<br> #1 / / / #2 / / /<br> #1 / / / #2 / / /
**AND Measles Mumps Rubella**<br> AND Positive Titer Date: / / /<br> Required [copy of lab report](#) within 5 years
**Hepatitis B**<br> #1 / / / #2 / / / #3 / / /<br> AND/OR Positive Titer Date: / / /<br> Required [copy of lab report](#)
- [EnergixB](#)
- [Recombivax](#)
- [HeplisavB](#)
**Tdap Td**<br> Tdap / / / Td / / /
- [DTP](#)
- [DT](#)
**Polio**<br> Primary series: [Oral](#) [Injectable](#)<br> Most recent booster: / / /
**Varicella (Chicken Pox)**<br> #1 / / / #2 / / /<br> AND Positive Titer Date: / / /
**Meningitis Serogroup ACWY Information Sheet**<br> #1 / / / #2 / / /<br> [Menomune](#) [Menactra](#) [Menevo](#)<br> [Meningitis information sheet](#) sign and submit
**Meningitis Serogroup B**<br> #1 / / / #2 / / / #3 / / /
- [Trumenba](#)
- [Bexsero](#)
**Influenza**<br> / / /
**COVID 19 Vaccine**<br> #1 / / / #2 / / /
- [Pfizer](#)
- [Moderna](#)
- [Johnson and Johnson](#)

2 doses of MMR OR 2 measles, 2 mumps, 2 rubella vaccine doses (single dose vaccines are not available)
First dose must be after the 1st birthday
A minimum of 28 days is required between the two MMR doses (single dose vaccines are not available)
Equivocal titers are considered negative
A copy of the lab report must be submitted as evidence of immunity.
3 dose series/2 dose series AND/OR A copy of the lab report must be submitted as evidence of immunity.
Minimum of 4 weeks between doses 1 and 2 (2 dose series [Heplisav-B](#))
Minimum of 8 weeks between doses 2 and 3
Minimum of 16 weeks between doses 1 and 3

Tdap (1 dose)
Td or Td within 10 years
Completed primary series
Completed Primary series or Positive Titer
2 doses varicella vaccine or history of disease and positive titer
Minimum of 4 weeks between doses if age 13 or older
This is a Requirement for students less than or equal to 23 years old and all university residents
Final dose must be administered at or after the age of 16 years AND within 5 years of entry
Required for all students ≤ 23 years of age
Within one year of program start and annual update
As per CDC and ACIP

**Signature Health Care Provider** ____________________________ **Print Name** ____________________________ **Date** ____________________________
**REQUwRD FORM B – IMMUNIZATION RECORD & TB SCREENING**

NAME: ______________________ D.O.B: ______________________

### REQUIRED TB SCREENING

| Interferon-gamma release assay tests (IGRA) | Result must be in *mm of induration for the PPD*  
<table>
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<tbody>
<tr>
<td>pos. □ neg. □ copy of report</td>
<td>A copy of the lab report must be submitted to demonstrate evidence of immunity</td>
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<tr>
<td>or 1) PPD ___ / ___ / ___</td>
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<tr>
<td>Plated</td>
<td></td>
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<tr>
<td>___ / ___ / ___ result ___ mm</td>
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<tr>
<td>or 2) PPD ___ / ___ / ___</td>
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<td>Plated</td>
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<tr>
<td>___ / ___ / ___ result ___ mm</td>
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<tr>
<td>Positive PPD in past</td>
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<td>___ / ___ / ___</td>
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<tr>
<td>BCG history</td>
<td></td>
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<td>___ / ___ / ___</td>
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<tr>
<td>If PPD or Interferon-gamma release assay tests (IGRA) is positive, chest x-ray is required:</td>
<td></td>
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<tr>
<td>chest x ray ___ / ___ / ___</td>
<td></td>
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<tr>
<td>Planted</td>
<td></td>
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<tr>
<td>___ / ___ / ___ result ___ mm</td>
<td></td>
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<tr>
<td>normal □ abnormal □</td>
<td></td>
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<tr>
<td>INH treatment began ___ / ___ / ___</td>
<td></td>
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<tr>
<td>completed ___ / ___ / ___</td>
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### HEALTH CARE PROVIDER

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print Name</th>
<th>Date</th>
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<table>
<thead>
<tr>
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<th>State</th>
<th>Zip</th>
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<th>Telephone</th>
<th>Fax</th>
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**Send Records by mail or fax a copy to:**

Saint Elizabeth University  
**Office of Student Health Services**  
Founders Hall  
2 Convent Road, Morristown, NJ 07960  
**Phone:** 973-290-4132 **Fax:** 973-290-4182

Upload to [https://www.steu.edu/student-life/health-services/secure-file-upload](https://www.steu.edu/student-life/health-services/secure-file-upload)
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 Saint Elizabeth University, all university 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 the 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__/__/__

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:
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
Required Form – D

Authorization to release information to the SEU Physician Assistant 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 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 SEU Physician Assistant Program in order to maintain a copy in my student record.

I am furthermore authorizing the SEU 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 the SEU 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:

Saint Elizabeth University
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.