PHYSICIAN ASSISTANT PROGRAM

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 requires documentation of immunizations and other medical requirements to be on file with both the Office of Student Health Services and Castlebranch prior to the first day of class.

ALL FORMS ARE DUE TWO WEEKS PRIOR TO THE START OF CLASS NO EXCEPTIONS.

Non-Compliance will result in a $350 fee and/or registration hold.

Please complete and upload to:

https://www.steu.edu/meduploads AND to Castlebranch (see link provided by the PA Program)

❑ REQUIRED FORM *A* - HEALTH FORM (6 pages)

- Release of Medical and Immunization to SEU 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- 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 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 and the Healthcare Provider Attestation to the Physician Assistant Program as required for Clinical Rotations.

☐ PHYSICIAN FORMS & GUIDELINES FOR REQUESTING MEDICAL EXEMPTIONS OF REQUIRED VACCINES

IF YOU NEED a medical exemption for any of the required immunizations, please read and follow the instructions. Although the University may accept medical exemptions. Clinical Affiliates have the right to decline your exemption during the First Year Experiences and during the Clinical Year and may not allow you to participate in supervised clinical practice experiences at their site.

COMPLETE AND UPLOAD FORMS TO:

https://www.steu.edu/meduploads AND Castlebranch (see link provided by the PA Program)

Immunization Information Line: 973-290-4388 ext 4388; or Immunization@steu.edu
For additional assistance, contact Health Services at (973) 290-4132

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) AND
  - **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.)
  - *Equivocal titers are considered negative*

- ❑ **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 with proof of immunity **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 + Booster** (As per CDC and ACIP)

- ❑ **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
  - Positive results must be addressed and include CXR results and documentation of treatment, if indicated

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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 to the Office of Accessibility Services. Forms and additional information may be accessed here.

Saint Elizabeth University
Accessibility Services
Mahoney Library
2 Convent Road
Morristown, New Jersey 07960
Phone: (973) 290-4261
accessibility@steu.edu

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. Service portals and additional information may be accessed here.

Saint Elizabeth University
Office of Counseling Services
Founders Hall
2 Convent Road
Morristown, New Jersey 07960
Phone: (973) 290-4175

Office Hours: Monday: 10-2; Tuesday: 10-2, 4-8; Wednesday: 10-2, 4-8; Thursday: 10-2; Friday: 10-2, 4-8
Saturday: 11-3; Sunday: CLOSED

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.

Immunization Information Line: 973-290-4388 ext 4388; or Immunization@steu.edu
For additional assistance, contact Health Services at (973) 290-4132

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Saint Elizabeth University
PHYSICIAN ASSISTANT PROGRAM

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

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 ____

Saint Elizabeth University
PHYSICIAN ASSISTANT PROGRAM

Required Form – A

IDENTIFICATION DATA

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: ______________

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

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

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

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***

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:

	Yes	No
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:

	Yes	No
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

	Yes	No
Hepatitis, mononucleosis, childhood diseases,	☐	☐
HIV	☐	☐
Loss or absence of any body parts.	☐	☐
Severe/frequent colds or flu	☐	☐
Serious illness or injury	☐	☐

ENT

	Yes	No
Any problems with your eyes, ears, nose or throat?	☐	☐
Hearing impairment	☐	☐
Loss of eye or eyesight	☐	☐

CARDIOVASCULAR:

	Yes	No
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

	Yes	No
Any problems with your skin?	☐	☐
Skin rashes	☐	☐
Acne	☐	☐
Eczema	☐	☐

ENDOCRINE

	Yes	No
Thyroid disease	☐	☐
Diabetes	☐	☐

URINARY

	Yes	No
Impaired function of any part of your urinary tract	☐	☐
Loss of a kidney	☐	☐
Recurrent urinary infection	☐	☐
Kidney Infection	☐	☐
Kidney stones	☐	☐

MENTAL HEALTH

	Yes	No
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

	Yes	No
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 - 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	Yes	No
Any serious disability, deformity or disease of bone, joint, or muscle?	❑	❑
Injury, neck, shoulder, back, knee, ankle, other	❑	❑
Arthritis	❑	❑

____
____

NEUROLOGY	Yes	No
Concussion/head injury	❑	❑
Seizures or convulsions	❑	❑
Fainting or blackouts	❑	❑
Dizziness	❑	❑
Recurrent headaches	❑	❑
Migraines	❑	❑

____
____

GASTROINTESTINAL	Yes	No
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	Yes	No
Are you following a special diet?	❑	❑
Do you have an eating disorder?	❑	❑
Unexplained weight loss / gain?	❑	❑

____
____

REPRODUCTIVE SYSTEM (men):	Yes	No
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):	Yes	No
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	Yes	No
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)

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

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: ____/____/_____

Saint Elizabeth University
PHYSICIAN ASSISTANT PROGRAM

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 _______ 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) _____________

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 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 University activities: including sports, physical education and intramurals

☐ Without restriction

☐ With the following restrictions and reason: ____

History Reviewed & Student Examined by:

Physician name (print): ______________________________ ***Date*** ______________________

Signature/stamp ____

Saint Elizabeth University
PHYSICIAN ASSISTANT PROGRAM

Required Form – A
Healthcare Provider Attestation

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/PA/NP

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

Healthcare Provider	Address/Stamp
Print Name	
Signature	Phone
Date	Fax

REQUIRED FORM - B
IMMUNIZATION RECORD & TB SCREENINGS

Saint Elizabeth University
PHYSICIAN ASSISTANT PROGRAM

NAME: ______________________ **D.O.B:** __________ **CLASS (YEAR):** __________

REQUIRED VACCINATIONS

Vaccines	Dates Given	SEU and NJ State Requirements
MMR OR Measles Mumps Rubella	#1 ___/___/___ #2 ___/___/___ OR #1 ___/___/___ #2 ___/___/___ #1 ___/___/___ #2 ___/___/___ #1 ___/___/___ #2 ___/___/___	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)
AND Measles **Mumps** **Rubella**	AND Positive Titer Date: ___/___/___ Required copy of lab report within 5 years AND Positive Titer Date ___/___/___ Required copy of lab report within 5 years AND Positive Titer Date: ___/___/___ Required copy of lab report within 5 years	*Equivocal titers are considered negative* **A copy of the lab report must be submitted as evidence of immunity.**
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ AND/OR Positive Titer Date: ___/___/___ Required copy of lab report	3 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* Minimum of 8 weeks *between doses 2 and 3* Minimum of 16 weeks *between doses 1 and 3*
Tdap Td	❑Tdap ___/___/___ ❑Td ___/___/___ ❑DTP ❑DT ___/___/___	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 Information Sheet	#1 ___/___/___ #2 ___/___/___ ❑ Menomune ❑ Menactra ❑ Menveo ❑ Meningitis information sheet sign and submit	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	#1___/___/___ #2___/___/___ #3___/___/___ ❑ Trumenba ❑ Bexsero	Required for all students ≤ 23 years of age

______________________ ______________________ __________
Signature Health Care Provider Print Name Date

(This form is invalid without the signature and or stamp of a healthcare provider)

NAME: ________________________ **D.O.B:**__________________________

Influenza	___/____/____	Within one year of program start and annual update
COVID19 Vaccine	#1___/____/___#2___/___/___#3___/___/___ ❑Pfizer ❑ Moderna ❑ Johnson and Johnson ❑other______________	As per CDC and ACIP
Interferon-gamma release assay tests (IGRA) or 2 step PPD / Mantoux	Interferon-gamma release assay tests (IGRA) ___/___/___ ❑ pos. ❑ neg. copy of report or 1)PPD ___/___/___ (Planted) ___/___/___ (Read) **result** ___**mm** 2)PPD ___/___/___ (Planted) ___/___/___ (Read) **result** ___**mm** Positive PPD in past ___/___/___ BCG history ___/___/___ If PPD or Inteferon-gamma release assay tests (IGRA) is positive, chest x-ray is required: **chest x ray** ___/___/___ ❑ normal ❑ abnormal INH treatment began ___/___/___ completed ___/___/___	Result must be in *mm of induration for the PPD* A copy of the lab report must be submitted to demonstrate evidence of immunity

HEALTH CARE PROVIDER

(This form is invalid without the signature and or stamp of a healthcare provider)

______________________ ______________________ ___/___/___
Signature Print Name Date

______________________ ____________ ____________ ____________
Address City State Zip

______________________ ______________________
Telephone Fax

UPLOAD TO:

https://www.steu.edu/meduploads
AND
to Castlebranch (See link provided by the PA Program)

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

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 univeristy 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.

<u>Send this required form to:</u>

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

Saint Elizabeth University
PHYSICIAN ASSISTANT PROGRAM

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 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:

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.

Vaccine Preventable Disease Program

GUIDANCE FOR REQUESTING A MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

The Department of Health, Vaccine Preventable Disease Program, received inquiries seeking guidance on obtaining medical exemptions from mandatory immunizations for children attending schools, preschools, and child care facilities in New Jersey. Specifically, the Department received questions on what should be included in the medical exemption documentation to ensure that it meets the requirements for the exemptions. In response, the Department is issuing this guidance document to assist healthcare providers, schools, preschools, child care facilities, and local health departments with medical exemptions for mandatory vaccines.

By way of background, N.J.A.C. 8:57 – 4.2 states that a "principal, director or other person in charge of a school, preschool, or child care facility shall not knowingly admit or retain any child whose parents or guardian has not submitted acceptable evidence of the child's immunization," according to the schedules specified in the rules. However, an unvaccinated child may attend a school, preschool, or child care facility if the required vaccination is medically contraindicated for the child. See N.J.A.C. 8:57-4.3. In order to obtain a medical exemption, N.J.A.C. 8:57-4.3 requires a written statement to be submitted to the school, preschool, or child care center by a physician licensed to practice medicine or osteopathy, or an advanced practice nurse who is licensed in any jurisdiction in the United States indicating that the immunization is medically contraindicated for the child for a specific period of time, and the reason(s) for the medical contraindication, based upon valid reasons as enumerated by the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service or the American Academy of Pediatrics (AAP) guidelines.

These guidelines are accessible on the CDC and AAP website at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://redbook.solutions.aap.org/redbook.aspx.

To assist treating healthcare providers with submitting adequate and sufficient medical exemption requests that meet the requirements of N.J.A.C. 8:57-4.3, and to guide school, preschools, child care facilities, and local health departments with determining whether an exemption is consistent with the rule requirements, the Department drafted the attached *Request for Medical Exemption from Mandatory Immunization* form that may be used for medical exemptions. Table 1. of the form lists the vaccines that are mandated for children to attend schools, preschools, and child care facilities and current ACIP contraindications and precautions for each vaccine. This form allows the healthcare provider to indicate the vaccine for which the exemption is sought as well as the ACIP contraindication or precaution that is recognized for that specific vaccine and applies to the child. In the event the form does not list the specific contraindication or precaution that exempts the child from a particular vaccine, the form also includes a space marked as "Other" where the healthcare provider may explain, in detail, the contraindication or precaution for the child's receipt of vaccine. The use of "Other" as a contraindication or precaution should be extremely rare, and the contraindication/precaution must be consistent with ACIP guidelines and established national standards for vaccination practices to be accepted. Table 2. of the form lists conditions that are **incorrectly** perceived as contraindications or precautions for vaccines, which provides further guidance to the healthcare provider in determining whether the exemption is valid and medically accepted.

The form will also assist schools, preschools, child care facilities, and local health departments in determining the validity of the exemption and whether it should be accepted or rejected. Specifically, the school, preschool, child care facility, and local health department may accept a medical exemption in which a healthcare provider indicates a contraindication or precaution listed in Table 1. However, a school, preschool, child care facility, and local health department should not accept a medical exemption in which a healthcare provider indicates a condition listed in Table 2.

It should be noted that healthcare providers who submit medical exemptions for mandatory vaccinations must ensure that the information submitted is accurate and verifiable. Supporting medical documentation may be requested by the school, preschool, or child care facility and/or by local or state public health authorities. Healthcare providers who misrepresent medical information may be referred to the New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

If a healthcare provider, school, preschool, or child care facility has questions about medical exemptions, it should direct the questions to the local health department with jurisdiction over the municipality in which the school is located. To locate the local health department, please visit the New Jersey Department of Health website at https://www.nj.gov/health/lh/community/index.shtml#1. Local health departments with questions can directly contact the Vaccine Preventable Disease Program at 609-826-4861.

Please also note that the use of the Form is not a mandate or requirement, but rather a tool that may be used by healthcare providers, schools, preschools, child care facilities, and local health departments in determining the validity of a medical exemption from a mandatory immunization.

INSTRUCTIONS FOR COMPLETION

It is easiest to use the latest version of Adobe Reader DC. If you do not have the latest version, download and install the free software by visiting this webpage: **https://get.adobe.com/reader/**

1. Fill out the form completely. ALL form fields are required except where noted as being optional.
   a. Enter the name of the Student and other identifying information.
   b. Check off each vaccine for which an exemption is requested.
      i. For each vaccine for which an exemption is requested, check to indicate whether the exemption is Temporary (indicate the date through which the exemption is valid) or Permanent.
      ii. Check the ACIP contraindication/precaution applicable for each vaccine for which an exemption is requested.
   c. If the contraindication/precaution is not included in Table 1, please put an "X" next to "Other" and fully explain. Please be sure that the contraindication/precaution does not appear in Table 2, that there is a valid contraindication/precaution noted for each vaccine for which an exemption is requested, and that the contraindication/precaution is consistent with ACIP/AAP guidelines and established national standards for vaccination practices.
2. Sign and date the Attestation Statement
3. Provide a copy to the person requesting the medical exemption or directly to the school, preschool or child care center.
4. Keep a copy of the form for your records.

New Jersey Department of Health
Vaccine Preventable Disease Program

REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

Name of Student: first / middle / last	Date of Birth:
Name of Parent/Guardian (if under 18): first / middle / last	Primary Phone:
Patient/Parent Home Address: address 1 address 2 city state zip	
Patient/Parent Email Address:	

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://redbook.solutions.aap.org/redbook.aspx

Please check the website to ensure that you are reviewing the most recent ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

Table 1. ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **DTaP, Tdap**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of DTP, DTaP, or Tdap **Precautions** ☐ Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP or Tdap until neurologic status clarified and stabilized ☐ Guillain-Barré syndrome < 6 weeks after previous dose of tetanus-toxoid-containing vaccine ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus toxoid-containing vaccine
☐ **DT, Td**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Guillain-Barré syndrome < 6 weeks after a previous dose of tetanus-toxoid-containing vaccine. ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria- or tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine

New Jersey Department of Health
Vaccine Preventable Disease Program

REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **Haemophilus influenzae type b (Hib)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
☐ **Hepatitis B (HepB)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Hypersensitivity to yeast
☐ **Inactivated poliovirus vaccine (IPV)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Pregnancy
☐ **Influenza, inactivated injectable (IIV)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component **Precautions** ☐ Guillain-Barré syndrome < 6 weeks after a previous dose of influenza vaccine ☐ Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, or recurrent emesis; or required epinephrine or another emergency medical intervention (IIV may be administered in an inpatient or outpatient medical setting, under the supervision of a healthcare provider who is able to recognize and manage severe allergic conditions)
☐ **Influenza, recombinant (RIV)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine **Precautions** ☐ Guillian-Barré syndrome < 6 weeks after a previous dose of influenza vaccine

New Jersey Department of Health
Vaccine Preventable Disease Program

REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **MMR**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Pregnancy ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with human immunodeficiency virus [HIV] infection who are severely immunocompromised) ☐ Family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test **Precautions** ☐ Recent (≤ 11 months) receipt of antibody-containing blood product (specific interval depends on product) ☐ History of thrombocytopenia or thrombocytopenic purpura ☐ Need for tuberculin skin testing or interferon gamma release assay (IGRA) testing
☐ **Meningococcal (MenACWY)**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
☐ **Meningococcal (MenB)**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Pregnancy
☐ **Pneumococcal (PCV13)**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid-containing vaccine or to a component of a vaccine (PCV13 or any diphtheria-toxoid-containing vaccine), including yeast

New Jersey Department of Health
Vaccine Preventable Disease Program

REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **Varicella**	☐ Temporary through: ☐ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or persons with HIV infection who are severely immunocompromised) ☐ Pregnancy ☐ Family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test **Precautions** ☐ Recent (≤ 11 months) receipt of antibody-containing blood product (specific interval depends on product) ☐ Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; avoid use of these antiviral drugs for 14 days after vaccination) ☐ Use of aspirin or aspirin-containing products

☐ Other. Please explain fully and attach additional sheets as necessary. Please be sure to check Table 2 below to ensure that the condition is not one incorrectly perceived as a contraindication or precaution.

Attestation

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation. I also understand that any misrepresentation might result in referral to the New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

Healthcare Provider Name (please print): ______________________ Specialty: ______________

NPI Number: ____________ License Number: ______________________ State of Licensure: __________

Phone: ______________ Fax: ______________ Email: ______________________

Address: ______________________ City: ______________ State: ______ Zip: __________

Signature: ______________________________ Date: ____________

New Jersey Department of Health
Vaccine Preventable Disease Program

REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

Table 2. Examples of Conditions incorrectly perceived as contraindications or precautions to vaccination* (i.e., vaccines may be given under these conditions)

Vaccine	Conditions incorrectly perceived as contraindications and precautions to vaccines (i.e., vaccines may be given under these conditions)
General for MMR, Hib, HepB, Varicella, PCV13, MenACWY	• History of Guillain-Barré syndrome • Recent exposure to an infectious disease • History of penicillin allergy, other nonvaccine allergies, relatives with allergies, or receiving allergen extract immunotherapy
DTaP	• Fever within 48 hours after vaccination with a previous dose of DTP or DTaP • Collapse or shock like state (i.e., hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP • Seizure ≤ 3 days after receiving a previous dose of DTP/DTaP • Persistent, inconsolable crying lasting ≥ 3 hours within 48 hours after receiving a previous dose of DTP/DTaP • Family history of seizures • Family history of sudden infant death syndrome • Family history of an adverse event after DTP/DTaP • Stable neurologic conditions (e.g., cerebral palsy, well-controlled seizures, or developmental delay)
Hepatitis B (HepB)	• Pregnancy • Autoimmune disease (e.g., systemic lupus erythematosus or rheumatoid arthritis)
Influenza, inactivated injectable (IIV)	• Nonsevere (e.g., contact) allergy to latex, thimerosal, or egg
MMR	• Breastfeeding • Pregnancy of recipient's mother or other close or household contact • Recipient is female of child-bearing age • Immunodeficient family member or household contact • Asymptomatic or mildly symptomatic HIV infection • Allergy to eggs
Tdap	• History of fever of ≥ 40.5° C (≥ 105° F) for < 48 hours after vaccination with previous dose of DTP/DTaP • History of collapse or shock-like state (hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP • History of persistent, inconsolable crying lasting > 3 hours within 48 hours of receiving a previous dose of DTP/DTaP • History of extensive limb swelling after DTP/DTaP/Td that is not an Arthus-type reaction • History of stable neurologic disorder • Immunosuppression
Varicella	• Pregnancy of recipient's mother or other close or household contact • Immunodeficient family member or household contact • Asymptomatic or mildly symptomatic HIV infection • Humoral immunodeficiency (e.g., agammaglobulinemia)

* For a complete list of conditions, please review the ACIP Guide to Contraindications and Precautions accessible at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.