Traditional Undergraduate Students - State of N.J. & Saint Elizabeth University Medical Requirements

TIME SENSITIVE REQUIREMENTS

DEADLINE: IMMEDIATELY prior to JUNE 15TH (FALL SEMESTER) DECEMBER 1ST (SPRING SEMESTER)

ALL HEALTH REQUIREMENTS MUST BE COMPLETED TO ATTEND CLASS
NON COMPLIANCE WILL LEAD TO FINANCIAL FEES $350, REGISTRATION HOLDS AND INABILITY TO RESIDE IN CAMPUS HOUSING

Complete, upload to: https://www.steu.edu/meduploads, or fax, mail
Health Services – Founders Hall, 2 Convent Road, Morristown, New Jersey 07960
Phone: 973-290-4132  Fax: 973-290-4182  Immunization Information Line: 973-290-4388 ext 4388

The Student is responsible for ensuring that all required forms are completed and the physician completes and signs all medical information. PLEASE READ and FOLLOW ALL INSTRUCTIONS CAREFULLY

☑ REQUIRED FORM A (1-4) - HEALTH FORM
   ☐ Identification Data (A1)
      Emergency Information
      Insurance Information/copy of insurance card
      Parental Endorsement for Medical Care (as indicated by age)
   ☐ History (A2-A3) and Physical (A4) must be within one year of entrance
      Reviewed/ completed/ signed by your physician

☑ REQUIRED FORM B - IMMUNIZATION RECORD
   ☐ Review, obtain and complete all required vaccines/ signed by your physician
      All students must fulfill the vaccine requirements prior to entrance.

☑ REQUIRED FORM C - MENINGITIS INFORMATION SHEET
   All students must read the information about meningitis & the vaccines
   ☐ All students must fill in, sign, date and submit the meningitis information sheet

Athletes
   • All potential athletes in addition must have a Pre-participation Athletic History, Physical and Clearance completed by their physician within 6 months prior to school entrance.
   • Please refer to the Athletic Dept. admission requirements for forms and information.
      o Athletic Trainer, at 973-290-4288 or mpawlsiak@steu.edu, Michael Pawlusiak

Immunization Records
Where can you obtain an acceptable record of immunization?
High school, college, university, healthcare provider, family records, employee health, state records

Acceptable Records?
The Record must show exact dates (month, day, year) and be signed/stamped by your physician or health care provider.
Start Immediately. Time Sensitive Requirements!

**Immunization Requirements**

- **History and Physical** must be **WITHIN ONE YEAR OF ENTRANCE**
- **MMR vaccine** 2 doses or blood work to show evidence of immunity - **Required**
  - Copy of lab report required within 5 years for evidence of immunity
  - Equivocal titers are considered negative
- **Meningitis serogroup ACWY vaccine** - **Required**
  - Final dose must be at or after the age of 16 years AND within 5 years of entry
  - All students less than or equal to 23 Years old – **Required**
  - All resident students - **Required**
- **Meningitis serogroup B** vaccine – **Required**
  - All students ≤ 23 years and further recommendation as per the CDC
- **Meningitis Information Sheet** – **Required**
- **Hepatitis B vaccine** – 3 dose series - **Required**
  - If history of Hepatitis B disease – evidence of immunity is required
  - Copy of lab report required for titers
  - 2 dose series of Hepislav-B for >18 years old also acceptable
- **Interferon-gamma release assay tests (IGRA) or PPD/Mantoux testing**
  - Required within one year of entry
  - RESULTS FOR PPD MUST BE IN MM OF INDURATION (record date planted/date read)
- **Tdap** – 1 dose **Required**
  - Td or Tdap within 10 years required
  - Primary series completed
- **COVID19-Required** as per CDC and ACIP
- **Polio vaccine- Required** Primary series completed

**Highly Recommended and Optional Vaccines**

- Flu, Varicella, HPV, Hepatitis A, Pneumococcal, HiB, Typhoid, Yellow Fever,
  These vaccines are not required but to promote preventive health care and management, these vaccines should be discussed with your physician.

**Without the above COMPLETE documented health records and required immunizations, you will be unable to reside in campus housing, attend class, register for future classes and incur financial fines of $350.**

**COMPLETED RECORDS MUST BE RECEIVED BY June 15th**

**UPLOAD TO:** [https://www.steu.edu/meduploads](https://www.steu.edu/meduploads) or mail or fax

**Health Services – Founders Hall**
**Saint Elizabeth University**
**2 Convent Road**
**Morristown, NJ, 07960**

**PHONE:** 973-290-4175 or 4132 **FAX:** 973-290-4182

Any questions, please call Immunization Information Line 973-290-4388 ext 4388
Email immunization@steu.edu
Note:
Medical records are strictly confidential and are used exclusively by the Student Health Service as required by Federal and State Law. Be aware immunization records are an exception and are not confidential. Your immunization records will be made available to state inspections and select university offices.

Psychological and Accessibility Services

The health form that you and your physician complete will be accessible only to STEU 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 accessibility accommodations, you must self identify and provide appropriate documentation directly to Lisa Seneca, Accessibilities Services Coordinator, at 973-290-4261 or lseneca@steu.edu.

Accessibilities Services
Saint Elizabeth University
Mahoney Library
2 Convent Road
Morristown, New Jersey 07690

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 A. Nagy, MA, dir.univ., LCSW, Director of Counseling Services, at 973-290-4134 or znagy@steu.edu.

Counseling Services
Saint Elizabeth University
Wellness Center
2 Convent Road
Morristown, New Jersey 07690

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 – HEALTH FORM (4 PAGES) – TRADITIONAL UNDERGRADUATE STUDENTS

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 __________
home __________________ cell __________

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

HEALTH INSURANCE COVERAGE

Please include a copy of your present health insurance card front and back.

Insurance Company __________________________ Address __________________________ Group and Policy# __________

Subscriber’s Name ____________ Subscriber’s DOB ____________ Subscriber’s SS # __________

EMERGENCY INFORMATION – contact to be notified in case of emergency

Name ___________________________ Relationship ___________________________
Home Address ___________________________ Tel.# __________________________
_________________________________________ Tel. # __________________________
Home __________________ work/cell __________________________________________

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

Name ___________________________ Relationship ___________________________
Tel.# __________________________

PARENTAL ENDORSEMENT FOR MEDICAL CARE

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

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

DATE: __________ SIGNATURE: ___________________________ RELATIONSHIP: ___________________________

SOURCES OF HEALTHCARE

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

<table>
<thead>
<tr>
<th>Name/specialty</th>
<th>Address</th>
<th>City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>Fax</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name/specialty</th>
<th>Address</th>
<th>City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>Fax</td>
<td></td>
</tr>
</tbody>
</table>
**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 [ ] [ ]

---

**RECORDED HISTORY**

**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(3) history**

**BLOOD:**
<table>
<thead>
<tr>
<th>Condition</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>

**BONE AND JOINT**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</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>

**NEUROLOGY**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</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>

**GASTROINTESTINAL**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</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 reflex</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>

**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>Condition</th>
<th>Relationship</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding problems</td>
<td>Brother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer or Tumor</td>
<td>Sister</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Grandfather</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Uncle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine</td>
<td>Grandfather</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are your parents living? number of brothers living number of sisters living number

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

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

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

**History Reviewed by Physician:**

Signature: ___________________________ Date: ___/___/___

**HEALTH AND NUTRITION**

<table>
<thead>
<tr>
<th>Question</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>

**REPRODUCTIVE SYSTEM (men):**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</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>

**REPRODUCTIVE SYSTEM (women):**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</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>

**ACCIDENT PREVENTION**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</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:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**HISTORY & PHYSICAL – UPDATED MARCH 21**
### Physical Examination

**Health History must be reviewed by the physician**

Physical exam to be completed by the physician and performed **within one year prior to entrance** to the University.

<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

**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** ____________________________

**Address** ____________________________

**Phone** _______________ **Fax** _______________
## REQUIRED VACCINES

<table>
<thead>
<tr>
<th>Vaccine/Information</th>
<th>Dates Given</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR</strong></td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td>2 doses or positive titers (must include copy of lab report within five years). Equivocal titers are considered negative. Minimum of 4 weeks between doses.</td>
</tr>
<tr>
<td>Measles Mumps Rubella</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td>Option of combined MMR OR 2 individual vaccine doses of measles, mumps, and rubella vaccines. Single dose vaccines are not manufactured any longer.</td>
</tr>
<tr>
<td><strong>Meningitis Vaccine</strong> Serogroup ACWY (required) (≥ age 16)</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___ (≥ age 16)</td>
<td>All students ≥ 16 years old AND within five years of entry. Further recommendation as per the CDC.</td>
</tr>
<tr>
<td><strong>Meningitis Vaccine</strong> Serogroup B (required)</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___ #3 <em><strong>/</strong></em>/___</td>
<td>All students ≥ 23 years. Further recommendation as per the CDC. Required as per CDC.</td>
</tr>
<tr>
<td><strong>Meningitis Information Sheet</strong></td>
<td></td>
<td>All students must read sign and submit meningococcal information sheet.</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___ #3 <em><strong>/</strong></em>/___</td>
<td>3 doses or positive titer (must include copy of lab report). Minimum of 4 weeks between doses 1 and 2 (for 2-dose series). Minimum of 8 weeks between doses 2 and 3. Minimum of 16 weeks between doses 1 and 3.</td>
</tr>
<tr>
<td><strong>Interferon-gamma release assay test (IGRA)</strong></td>
<td></td>
<td>Must send copy of Interferon-gamma release assay test (IGRA) report.</td>
</tr>
<tr>
<td><strong>PPD / Mantoux</strong></td>
<td></td>
<td>Result must be in: mm of induration. <strong>WITHIN ONE YEAR</strong> must include planted and read dates.</td>
</tr>
<tr>
<td><strong>Td</strong></td>
<td>Tdap <em><strong>/</strong></em>/___ #1 <em><strong>/</strong></em>/___ Td <em><strong>/</strong></em>/___ DTP <em><strong>/</strong></em>/___ DT <em><strong>/</strong></em>/___</td>
<td>Tdap 1 dose required. Td or Tdap within 10 years.</td>
</tr>
<tr>
<td><strong>Polio</strong></td>
<td></td>
<td>Primary series: Oral Injectable. Most recent booster: <strong>/</strong>/___</td>
</tr>
<tr>
<td><strong>COVID 19</strong></td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___ #3 <em><strong>/</strong></em>/___</td>
<td>As per CDC and ACIP.</td>
</tr>
</tbody>
</table>

### Additional Information
- **INH treatment began** ___/___/___ completed ___/___/___
- Minimum of 4 weeks between doses 1 and 2 (for 2-dose series).
- Minimum of 8 weeks between doses 2 and 3.
- Minimum of 16 weeks between doses 1 and 3.
- Minimum of 4 weeks between doses 1 and 2 (for 2-dose series).
- Minimum of 8 weeks between doses 2 and 3.
- Minimum of 16 weeks between doses 1 and 3.
## FORM B (2) IMMUNIZATION RECORD

**Name______________________**

**Date of Birth_____/_____/______**

### RECOMMENDED VACCINES

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Varicella</strong></td>
<td>#1__/<strong>/</strong>  #2__/<strong>/</strong></td>
<td>Strong Recommendation 2 doses varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses if age 13 or older</td>
</tr>
<tr>
<td>(Chicken Pox)</td>
<td>OR Positive Titer Date: <strong>/</strong>/__</td>
<td>Required by Nutrition, PA, and Nursing Departments</td>
</tr>
<tr>
<td></td>
<td>History of disease [No] [Yes] Date <em><strong>/</strong>/</em>_</td>
<td></td>
</tr>
<tr>
<td><strong>HPV</strong></td>
<td>#1__/<strong>/</strong>  #2__/<strong>/</strong>  #3__/<strong>/</strong></td>
<td>Strong Recommendation Preventative health care</td>
</tr>
<tr>
<td></td>
<td>[Gardasil]  [Cervarix]  [Gardasil-9]</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>#1__/<strong>/</strong>  #2__/<strong>/</strong></td>
<td>As recommended by the CDC 6-12 months between doses 1 and 2</td>
</tr>
<tr>
<td><strong>Pneumococcal</strong></td>
<td>#1__/<strong>/</strong></td>
<td>As recommended by the CDC</td>
</tr>
<tr>
<td></td>
<td>[Polysaccharide (PPV)]  [Conjugate (PCV)13]  [PPSV 23]</td>
<td></td>
</tr>
<tr>
<td><strong>Hib</strong></td>
<td><strong>/</strong>/__</td>
<td>Primary series completed</td>
</tr>
<tr>
<td><strong>Flu</strong></td>
<td><strong>/</strong>/__</td>
<td>Highly Recommended Seasonal</td>
</tr>
</tbody>
</table>

### OPTIONAL VACCINES

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Typhoid</strong></td>
<td>#1__/<strong>/</strong></td>
<td>Travel</td>
</tr>
<tr>
<td><strong>Yellow Fever</strong></td>
<td>#1__/<strong>/</strong></td>
<td>Travel</td>
</tr>
</tbody>
</table>

### HEALTH CARE PROVIDER

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

Upload to [https://www.steu.edu/meduploads](https://www.steu.edu/meduploads) or fax, or mail

Saint Elizabeth University
Health Services – Founders Hall
2 Convent Road, Morristown, N.J. 07960

**PHONE:** 973-290-4175 or 4132  **FAX:** 973-290-4182

*Any questions, call Immunization Information Line:* 973-290-4388 ext 4388 / immunization@steu.edu

TRADITIONAL UNDEGRADUATE STUDENTS - IMMUNIZATION RECORD – REQUIRED FORM B (1-2) Updated May 2021
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 Saint Elizabeth University, all students must complete and return this form to the address below.

1) The University is to provide information about meningococcal meningitis, the disease, its severity, causes, disease prevention, treatment and the availability of the vaccine to prevent disease to all their students prior to matriculation (please see attached Meningococcal Disease Information Statement)

2) Meningitis Vaccine recommendations are as per The Center for Disease Control (CDC) and The Advisory Committee on Immunization Practices (ACIP). Read this information on the Vaccine Information Statement, “Who should get Meningococcal vaccine and when.”

3) The University is to document the student’s receipt of the meningococcal information and their decision whether or not to receive a meningitis vaccine.

Students may go to their private physician or other healthcare provider for administration of the meningitis vaccine. Arrangements can be made with Saint Elizabeth University Health Services for administration of the meningitis vaccine, if needed.

Complete and Sign all indicated below:

Yes □ No □ I have received information (What you need to know – Vaccine Information Statement) about meningitis, the vaccine, and its availability.

Yes □ No □ I have received the meningococcal (serogroup ACWY) vaccine. See Vaccine Information Statement as to “Meningococcal vaccines what you need to know”.

Date #1 __/__/__ #2 __/__/__

Yes □ No □ I have received the meningitis (serogroup B) vaccine. See Vaccine Information Statement as to “Serogroup B Meningococcal vaccine: what you need to know”.

Date #1 __/__/__ #2 __/__/__ #3 __/__/__

Yes □ No □ 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.

upload this required form to:
https://www.steu.edu/meduploads or fax or mail
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

TRADITIONAL UNDERGRADUATE STUDENTS – MENINGITIS INFORMATION SHEET REQUIRED FORM #3
Updated March 21
Authorization to Release Medical and Immunization Records to Saint Elizabeth University Health Services

Date ________________________________

Student Name _______________________________________________________

Date of Birth _______ / _______ / _______

Address _______________________________________________________________________________________

City ____________________________ State _________________________ Zip Code _________________

Phone Number _______ - ________ - ____________

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

to release (check all those that are indicated)

☐ Immunization Records ☐ Medical Records

to Health Services at Saint Elizabeth University. Please forward my records to:

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

If you wish, you may upload the information to www.steu.edu/meduploads or fax to (973) 290-4182.
Questions/Concerns, please call (973) 290-4132 or 4175.

Signature/Date ____________________________________________________________

Name of Parent or Guardian (if under 18) ________________________________

Signature of Parent or Guardian (if under 18) ________________________________

Relationship to patient ________________________________________________
Meningococcal ACWY Vaccine: What You Need to Know

**1 Why get vaccinated?**

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

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

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

**2 Meningococcal ACWY vaccine**

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

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

**3 Talk with your health care provider**

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

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

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

Your health care provider can give you more information.

4 Risks of a vaccine reaction

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

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

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

5 What if there is a serious problem?

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

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

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

6 The National Vaccine Injury Compensation Program

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

7 How can I learn more?

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

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

1 Why get vaccinated?

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

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

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

2 Meningococcal B vaccine

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

Meningococcal B vaccines are recommended for people 10 years or older who are at increased risk for serogroup B meningococcal disease, including:
- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called “persistent complement component deficiency”
- Anyone taking a type of drug called a complement inhibitor, such as eculizumab (also called Soliris®) or ravulizumab (also called Ultomiris®)
- Microbiologists who routinely work with isolates of N. meningitidis

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

3 Talk with your health care provider

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

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

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

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

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

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

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

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