Traditional Undergraduate Students
State of NJ and Saint Elizabeth University Medical Requirements

TIME SENSITIVE REQUIREMENTS

DEADLINES:

FALL SEMESTER – DUE on or before June 15th
SPRING SEMESTER – DUE on or before January 15th

ALL HEALTH REQUIREMENTS MUST BE COMPLETED TO ATTEND CLASS OR TO MOVE IN
NON-COMPLIANCE WILL LEAD TO FINANCIAL FEES $300 AND REGISTRATION HOLDS

Complete and upload to: https://www.steu.edu/student-life/wellness-center/forms.html or mail
Health Services – Founders Hall, 2 Convent Road, Morristown, New Jersey 07960
Phone: 973-290-4132 Fax: 973-290-4182

Dear Student,

Congratulations on taking the next steps towards your future. This is an exciting time with a lot of information surrounding your entry to Saint Elizabeth University. In order to facilitate a seamless transition, please read, fill out, and submit all of the required health forms A-D prior to the deadline. Health records must show exact dates (month, day, and year) and be signed/stamped by your physician or health care provider. Students are responsible for ensuring all required forms are completed and signed by their physician. **If you do not complete the required forms, you will be unable to reside on campus, attend class, register for future classes, and incur financial fines minimally of $300.**

1) **REQUIRED FORM A (pgs. 3-8) HEALTH FORM**

a) IDENTIFICATION DATA (A1)
   i) Emergency Information
   ii) Health Insurance Information (please provide copy of card)
   iii) Parental Endorsement as indicated by age

b) HEALTH HISTORY and PHYSICAL (A2)
   i) Self-reported Medical History (pgs. 4-6)
   ii) Physical Examination Form (pg. 7) MUST BE WITHIN ONE YEAR OF ENTRY
   iii) Physical Evaluation Clearance Form (pg. 8)

2) **REQUIRED FORM B (pg. 9) - IMMUNIZATION RECORDS**

a) Students must fulfill **ALL** vaccination requirements **PRIOR** to entrance.
b) All required vaccinations must be signed by your physician.
c) These records can be obtained through your high school, college, university, healthcare provider, medical records, employee records, and state.

3) REQUIRED FORM C (pg. 10) - TUBERCULOSIS SCREENING

a) Either Interferon-gamma release assay tests (IGRA) or PPD implantation are acceptable.
b) Must be completed within one year of entry.
c) PPD implanted results must be recorded in **mm of induration and signed by a physician.**
d) If an IGRA is obtained, a copy of the report must be submitted.

4) REQUIRED FORM D (pg. 11) - MENINGITIS INFORMATION SHEET

a) Please read information about Meningitis & Vaccines.
b) Students **MUST** sign, date, and submit the meningitis information sheet.

NOTE: Medical records are strictly confidential and are exclusively used by the Student Health Services as required by Federal and State Law. **Be aware immunizations records are an exception and are not confidential.** Your immunization records will be made available to state inspections and select university offices.

ALL VACCINATION REQUIREMENTS

- **MMR:** vaccine 2 doses or blood work showing evidence of immunity (Lab work MUST be within 5 years for evidence of immunity). Any Equivocal titers are considered Negative and student MUST receive another dose of the MMR vaccine.
- **Meningitis serogroup ACWY vaccine:** 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.
- **Hepatitis B vaccine:** 3 doses Required **OR** a copy of lab report for titers **OR** 2 dose series of Hepilav-B for age 18 or older.
    - If history of Hepatitis B disease, evidence of immunity is required.

Highly Recommended and Optional Vaccines (please provide proof of immunization)

- Meningitis serogroup B: All students 23 years or younger
- Tdap: vaccine: 1 dose within 10 years and completed primary series
- Polio vaccine: Completed primary series
- Hepatitis A: Recommended by the CDC (6-12 months between doses 1 and 2)
- Varicella vaccine: REQUIRED for Nutrition, PA and Nursing programs
- HPV vaccine
- Flu vaccine: Seasonal
- COVID-19 vaccine

These vaccines are not required, however, they promote preventive health care and management, please consult your physician for further information.

ATHLETES ONLY

- All potential athletes must have Form A completed prior to participation.
- EKG and sickle cell testing is mandatory in accordance with NCAA regulations.
- Please refer to the Athletics' website - Inside Athletics - Sports Medicine/Physicals for forms and additional information.

Psychological and Accessibility Services

If you require accessibility accommodations, please reach out directly to the Accessibility Services Coordinator, at 973-290-4261. Mental Health Services are also available to ALL students. If you need services, please visit the Counseling Services website: https://www.steu.edu/student-life/counseling-services

COMPLETED RECORDS MUST BE RECEIVED BY June 15th
RECORDS CAN BE DROPPED OFF OR SENT BY MAIL, FAX, OR UPLOADED TO:

https://www.steu.edu/student-life/wellness-center/forms.html

Health Services - Founders Hall
2 Convent Road, Morristown, NJ, 07960
PHONE: 973-290-4132 FAX: 973-290-4182
Any questions please call or email immunization@steu.edu

Saint Elizabeth University

REQUIRED FORM A

REQUIRED FORM A – HEALTH FORM (6 PAGES) – TRADITIONAL UNDERGRADUATE STUDENTS

Health Services – Founders Hall - 2 Convent Road - Morristown, NJ 07960
Phone Number: ***973-290-4132, 4175*** Fax Number: ***973-290-4182*** Immunization Information Number: ***973-290-4388***

IDENTIFICATION DATA

Name _____ _____/_____/_____
Last First Middle Date of Birth (mm/dd/yyyy)

Home Address _____
Street City State Zip Code

State/Country of Origin _____ Telephone _____ Email _____

First Seme ter 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.# _____

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 Saint Elizabeth Health Services to examine and treat my minor child for all medical problems and injuries that may occur while they are on campus.

DATE: _____ SIGNATURE: _____ RELATIONSHIP: _____

SOURCES OF HEALTHCARE

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

Name/specialty
Address
City, State
Telephone Fax

Name/specialty
Address
City, State
Telephone Fax

Print Full Name: _____ **Date of Birth**: _____

Medication		
Name of medication	**Dosage**	**Reason for Taking**

Allergies	
Allergen (e.g. Medications, Insects, Food, etc.)	**Reaction** (e.g. Anaphylaxis, Rash, Vomiting, etc.)

PHQ-9 Questionnaire				
Directions: Circle the number that corresponds with how often over the last two weeks you felt	**Not at all**	**Several days**	**More than half the days**	**Mostly everyday**
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thought that you would be better off dead, or of hurting yourself	0	1	2	3
Totals				
Score				

Print Full Name: _____ **Date of Birth** _____

Directions: Please check "Yes" "No" to the following questions below.

General Medical History	Yes	No
Have you ever been denied or restricted from participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify. □ Anemia □ Asthma □ Diabetes □ Infections Other: _____		
Have you ever used or are currently using an inhaler or take asthma medication?		
Have you ever gone to the hospital? Specify the reason on the next page.		
Have you ever had surgery?		
Were you born without or are you missing a kidney, an eye, a testicle(males), your spleen, or any other organ?		
Do you have groin pain or painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis(mono) within the last month?		
Do you have any rashes, pressure sores, or other skin problems?		
Have you had herpes or MRSA skin infection?		
Have you ever had a head injury or concussion?		
Have you had a hit or blow to the head that resulted in unconsciousness, memory loss, confusion or prolonged headaches?		
Have you ever had any numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Have you ever been unable to move your arms or legs after being hit or from falling?		
Have you ever become ill while exercising in the heat?		
Do you get muscle cramps often while exercising?		
Do you or someone in your family have sickle cell disease?		
Have you had any problems with your vision or eyes?		
Have you had any eye injuries?		
Do you wear glasses or contact lenses?		
Have you ever had an eating disorder?		
Do you have any concerns that you would like to discuss with doctor?		
Have you been diagnosed with coronavirus (COVID-19)?		
If diagnosed with Coronavirus (COVID-19) were you symptomatic?		
If diagnosed with Coronavirus (COVID-19) were you hospitalized?		
Females Health History	Yes	No
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months? ( )		

Family Health History	Yes	No
Has anyone in your family died from heart problems/complication or had an unexpected or unexplained sudden death before age 50?		
Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Cardiac History	Yes	No
Have you ever passed out or nearly passed out during or after exercising?		
Have you ever had any chest tightness, pain, or pressure during or after exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ Heart murmur □ High cholesterol □ Heart infection □ Kawaski disease □ Other: _____		
Have you ever had a test ordered for your heart? (ECG, EKG, echocardiogram)		
Do you get more tired or short or breath more quickly than your friends during exercise?		
Have you ever had an unexplained seizure?		
Musculoskeletal History	Yes	No
Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
Have you ever had any broken or fractured bones or dislocated joints?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
Have you ever had a stress fracture?		
Have you ever been told that you have or told you require an x-ray for neck instability or atlantoaxial instability?		
Do you regularly use a brace, orthotics, or other assistive devices?		
Do any of your joints become painful, swollen, feel warm, or look red?		
Do you have a history of juvenile arthritis or connective tissue disease?		

Print Full Name: _____

Directions: If you answered "yes" to any of the question on the previous page, please explain to the best of your knowledge below on the lines provided.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Date | Student Name (Printed) | Signature of Student

Physical Examination Form

Print Full Name_____ Gender _____ Age_____ Date of Birth_____

PHYSCIAN REMINDER

1. Consider additional questions on more sensitive issues
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

EXAMINATION		
Height: **Weight:** **□ Male □ Female**		
BP (/) HR: **Vision R 20/** **L 20/** **Corrected Y N**		
MEDICAL	NORMAL	ABNORMAL FINDINGS COMMENTS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodctyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse		
Pulse • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary(males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

- Consider EKG, echocardiogram, and referral to cardiology for abnormal cardiac, history of exam.
- Consider GU exam if in private setting. Having third party present is recommended.
- Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Signature of Physician, APN, PA_____Date of Exam _____

Physical Evaluation Clearance Form

Print Full Name_____ Sex □ M □ F Age_____ Date of Birth_____

□ Cleared for all sports without restriction

□ Cleared for all sports without restriction with recommendations for further evaluation or treatment for_____

□ Not Cleared

□ Pending further evaluation
□ For any sports
□ For certain sports_____

Recommendations

_____
_____
_____
_____

EMERGENCY INFORAMITON

Allergies

_____
_____
_____
_____
_____

Other information

_____
_____
_____
_____
_____

OFFICE STAMP

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Office Name _____

Address_____Phone_____

Printed name of physician, advance practice nurse (APN), physician assistant(PA)_____

Signature of Physician, APN, PA_____Date of Exam _____

REQUIRED FORM B (1) – IMMUNIZATION RECORD ***START IMMEDIATELY – TIME SENSITIVE REQUIREMENTS!***

SAINT ELIZABETH UNIVERSITY TRADITIONAL UNDERGRADUATE STUDENTS

Name_____Class (year)_____Date of Birth___/____/_____

REQUIRED VACCINES **READ ALL INSTRUCTIONS CAREFULLY**

	Dates Given	Saint Elizabeth University and NJ State Requirements
MMR	#1 ___/ ___/ __ #2 ___/ ___/ ____ **1st** dose given after **1st** birthday. Minimum of 4 weeks between doses	**2** doses or ***positive titers*** ***(must include copy of lab report within five years)*** **Equivocal titers are considered negative** Option of combined MMR OR **2** individual vaccine doses
or Measles Mumps Rubella	nes. #1 ___/ ___/ ___ #2 ___/ ___/ _ **OR Positive Titer Date**: ___/ ___/___***lab report required*** #1 ___ / ____/ ____ #2____/____/ ____ **OR Positive Titer Date** ___/___ /____***lab report required*** #1____/____/ ____ #2____/____ /____ **OR Positive Titer Date:** ____/___ / __***lab report required***	Single dose vaccines are not manufactured any longer
Meningitis Vaccine Serogroup **ACWY** **(required)** **(≥ age 16)**	#1 ____/ ____/ ____ **#2** ____/ ___ / ___***(≥ age 16)*** ☐ **Menomune** ☐ **Menactra** ☐ **Menveo**	**All** students ≤ 23 years. **All** resident students ***Final dose must be at or after the age of 16 years old AND within five years of entry*** **Further recommendation as per the CDC**
Hepatitis B	#1 ___/ ___/ ____ #2 _/ /_____ #3 ____/ _/_____ OR Positive Titer Date: ___/ ___/ __***lab report required*** ☐ **Energrix B** ☐ **Recombivax B** ☐ **Heplisav B**	**3 doses** or **positive titer** *(must include copy of lab reports)* Minimum of **4 weeks** between *doses 1 and 2* (for2dose series) Minimum of **8 weeks** between *doses 2 and 3* Minimum of **16 weeks** between *doses 1 and 3*

HEALTH CARE PROVIDER

_____ _____/_____/_____

Signature Print Name Date

_____ _____ _____ _____

Address City State Zip

_____ _____

Telephone Fax

Send Records by mail, fax or upload to:

https://www.steu.edu/student-life/wellness-center/forms.html

Health Services - Founders Hall
2 Convent Road, Morristown, NJ, 07960
PHONE: 973-290-4132 FAX: 973-290-4182
Any questions please call or email immunization@steu.edu

SAINT ELIZABETH UNIVERSITY TRADITIONAL UNDERGRADUATE STUDENTS

TUBERCULOSIS SCREENING

In accordance with Centers of Disease and Prevention Centers (CDC) and New Jersey State Law, all students are required to be screened for tuberculosis. Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. This bacteria usually attacks the lungs, but can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick, so screening for TB is extremely important.

There are two ways to complete the TB screening:

- Interferon-gamma release assay test (IGRA)
- Purified protein derivative (PPD) skin test

NAME: _____ Date of Birth: ___/___/____

(IGRA) Interferon-gamma release assay test

MUST be within the last year and copy of lab report required.

Date Obtained: _____/_____/_____ _____Pos. _____Neg.

(PPD) Purified protein derivative

MUST be within the last year & skin test MUST be read within 3 days of implantation.

Date implanted: _____/_____/_____ Date read: _____/_____/_____

Result: _____mm

Past Positive PPD: _____/_____/_____ BCG vaccine history _____/_____/_____

- ❖ If PPD or IGRA is positive, a chest x-ray MUST be obtained and results provided.

  Date of chest x-ray: _____/_____/_____ Results: _____

- ❖ If treated for tuberculosis, please provide dates treatment began and completed.

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 college is to provide information about meningococcal meningitis, the disease, its severity, causes, disease prevention, treatment and the availability of the vaccine to prevent disease to all their students prior to matriculation (please see attached Meningococcal Disease Information Statement)
2) Meningitis Vaccine recommendations are as per ***The Center for Disease Control (CDC)*** and ***The Advisory Committee on Immunization Practices (ACIP).*** Read this information on the Vaccine Information Statement, "Who should get Meningococcal vaccine and when."
3) The college is to document the student's receipt of the meningococcal information and their decision whether or not to receive a meningitis vaccine.

Students may go to their private physician or other healthcare provider for administration of the meningitis vaccine. Arrangements can be made with the 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 ☐ 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'sor guardian'ssignature is required)

This signature shall become part of the student's healthrecordand is being requiredby New Jersey law, P.L. 2000c.25.

Send or upload this required form to:
https://www.steu.edu/student-life/health-services/secure-file-upload
Saint Elizabeth University
Health Services – Founders Hall
2 Convent Road
Morristown, NJ 07960
PHONE: (973) 290-4132 **FAX:** (973) 290-4182
Any questions please call or email immunization@steu.edu

Authorization to Release Medical and Immunization Records to Saint Elizabeth University Health Services

Saint Elizabeth University
MORRISTOWN, NJ

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: Shaleah Mitchell, Medical Records Coordinator
Medical Records Coordinator email: smitchell@steu.edu
Medical Records Coordinator phone: (973) 290-4132

If you wish, you may upload the information to:
https://www.steu.edu/student-life/wellness-center/forms.html
or fax to: (973) 290-4182. Any questions please call or email immunization@steu.edu.

Signature /Date _____

Name of Parent or Guardian (if under 18) _____

Signature of Parent or Guardian (if under 18) _____

Relationship to patient _____