Nursing Students - State of N.J. State Board of Nursing & College of St. Elizabeth Medical Requirements

READ IMPORTANT INFORMATION - 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 REGISTRATION HOLDS

READ and FOLLOW ALL INSTRUCTIONS CAREFULLY

Complete and make 2 copies - SEND one copy to Health Services and one copy to the Nursing Department:

Health Services, College of Saint Elizabeth, Founders Hall, 2 Convent Road, Morristown, NJ 07960
Immunization Information Line: 973-290-4388 **Phone:** 973-290-4132 **Fax:** 973-290-4182

Nursing Program - Immunizations, College of Saint Elizabeth, 2 Convent Road, Morristown NJ 07960 Attn. Janet Okken
Phone: 973-290-4139 **Fax:** 973 290 4177

- The Student is responsible for ensuring that these documents **ARE SUBMITTED TO BOTH THE HEALTH SERVICES AND NURSING DEPARTMENT**

- The Student is responsible for ensuring that all required **FORMS ARE COMPLETED AND THE PHYSICIAN COMPLETES ALL MEDICAL INFORMATION.**

- [ ] **REQUIRED FORM *A* - HEALTH FORM**
  - Identification Data
  - Emergency Information
  - Parental Endorsement for Medical Care (as indicated by age)
  - Personal and Family Medical History (reviewed/completed by your physician)
  - History and Physical must be **within one year of entrance**

- [ ] **REQUIRED FORM *B* - IMMUNIZATION RECORD**
  - Review requirements/ completed by your physician

- [ ] **REQUIRED FORM *C* - MENINGITIS INFORMATION SHEET**
  - All students must read the information about meningitis & the vaccine
  - All students must sign and submit the meningitis information sheet

Immunization Requirements –Start Immediately-Time Sensitive Requirements!!!!!

Where can you obtain an acceptable record of immunization?

High school, college, university, healthcare provider, family records

Acceptable Records?

The Record must show exact dates (month, day, year) and be signed by your physician or health care provider

- **History and Physical** must be **within one year of entrance**
- **MMR** vaccine **2** doses or **2 measles, 2 mumps, 2 rubella** or evidence of immunity- **REQUIRED**
    - **First dose must be after the 1st birthday**
    - **Be aware! Between the two MMR doses a minimum of 28 days is required**
    - Copy of lab report for immunity done within **5 years**
- **Meningococcal vaccine**
    - All students must complete the Meningitis Information Sheet
    - Vaccine is required for all incoming **resident** students only **(within 5 years)**
- **Hepatitis B vaccine** – 3 dose series or evidence of immunity **REQUIRED**
    - Copy of lab report required
    - 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
- **PPD /Mantoux testing** or **IGRA-Interferon-gamma release assay** – **required** within one year of entry
    - **Result must be in mm of induration for the PPD**
- **Tdap or Td vaccine** - **REQUIRED**

    Primary series completed
    Booster within 10 years
    (One dose of Tdap recommended)
- **Polio vaccine**

    Primary series completed
- **Varicella vaccine 2** doses and/or evidence of immunity - **REQUIRED**

    Copy of lab report for immunity **REQUIRED**

Recommended and Optional Vaccines

HPV, Hepatitis A, Pneumococcal, Typhoid, HIB, 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 attend class, register for future classes and incur financial fines.

COMPLETED RECORDS MUST BE RECEIVED BY JUNE 15TH

Send Records by mail or fax one copy to the Health Service and one copy to the Nursing Department:

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

Nursing Program - Immunizations, College of Saint Elizabeth, 2 Convent Road, Morristown NJ 07960 **Attn. Janet Okken**
Fax: 973-290-4177 **Phone**: 973-290-4139

Any questions, please call **Immunization Information Line** 973-290-4388

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 Disability Services

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

If you require disability accommodations, **you must** self identify and provide appropriate documentation directly to **William Moesch, Disabilities Services Coordinator, at 973-290-4261 or** wmoesch@cse.edu.

Disability Services
College of St. Elizabeth
Mahoney Library
2 Convent Road
Morristown, New Jersey 07960

If you have a mental health condition and/or take psychiatric medication and want Counseling Services to be aware of your history, **you must** self identify and provide appropriate documentation directly to **Sharon McNulty, LPC, Director of Counseling Services, at 973-290-4134 or** smcnulty@cse.edu.

Counseling Services
College of St. Elizabeth
Founders Hall
2 Convent Road
Morristown, New Jersey 07960

If you choose to sign release of information forms, these three service areas can coordinate your care. For further details or questions, please contact these individual offices.

REQUIRED FORM A – HEALTH FORM (4 PAGES) – NURSING 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 /Maiden name   First   Middle   Date of Birth

Home Address____
Street   City   State   Zip Code

State/Country of Origin__________________________ Telephone ______________________________
home   cell

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

CSE Leave Of Absence ____/____ (M/Y)   CSE Withdrawal ____/____ (M/Y)   CSE Dismissal ____/____ (M/Y)

HEALTH INSURANCE COVERAGE

____
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.#___________________________
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's 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 St. 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 St. 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.

Name/specialty	
Address	
City, State	
Telephone	Fax

Name/specialty	
Address	
City, State	
Telephone	Fax

College of St. Elizabeth
Health History Questionnaire
Completed by student and physician

Name: ___________________________________

Answer ALL questions ***Explain All YES Answers***

Date of Birth: ___________

ALLERGY

	Yes	No
Any significant allergy to food, medications, insects, pollen?	☐	☐
List known allergies and type of reaction to them:		
Medication..	☐	☐
Food..	☐	☐
Environmental..	☐	☐

____
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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, etc.)

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HOSPITALIZATION:

	Yes	No
Have you ever been admitted to a hospital?	☐	☐
Have you ever had surgery?	☐	☐
Have you ever had any ER visits?	☐	☐

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PAST ILLNESSES

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

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EENT

	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	☐	☐

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RESPIRATORY:

	Yes	No
Asthma	☐	☐
Tuberculosis	☐	☐
Chest infection (pneumonia)	☐	☐
Do you smoke cigarettes?	☐	☐
How many?__ How long?___		
Shortness of breath	☐	☐
Wheezing	☐	☐
Chronic cough	☐	☐

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SKIN

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

____
____

ENDOCRINE

	Yes	No
Thyroid disease	☐	☐
Diabetes	☐	☐

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URINARY

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

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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?	☐	☐

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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?	☐	☐

Please give specific information about drug usage (ex. Marijuana, pain medication, ecstasy)

____
____

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

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

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

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

____
____

HEALTH AND NUTRITION	Yes	No
Are you following a special diet?	☐	☐
Do you have an eating disorder?	☐	☐

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____
____

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

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

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

Additional Explanations:

____
____
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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	___________Heart Disease	________Mental Illness
____________Asthma	___________Sudden death before age 50	________Tuberculosis
____________Cancer or Tumor	___________ Stroke	________Gyn. Disorders
____________Diabetes	___________ Kidney Disease/Bladder Disease	________Rheumatology
____________High Blood Pressure	___________ Thyroid Disease	________Seizure
____________High Cholesterol	___________ Alcoholism/Drug Abuse	________Migraine

Are your parents living? ________# of brothers living ________# of sisters living ________

If deceased, give relationship and cause of death ______________________________

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

Student Signature: ____ Date: ____/____/_____

History Reviewed by Physician- Signature: ___________________________________ Date: ____/____/_____

College of St. Elizabeth Health Service

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 College

Patient Name ___________________________________ Sex M/F Date of Birth _________ Date of Exam __/__/____

Vision: *uncorrected* Right 20/ ______ Left 20/ ______; *with glasses/contacts* Right 20/ _____Left 20/_____

Hearing: normal ❑ Yes ❑ No Abnormal____

Height _______ Weight _______ BP _______ P _______ Resp _______

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 Protein _______ Glucose _______ Blood _______
BLOOD T. Cholesterol (Fasting) _______ CBC _______
Additional labs as indicated ____

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

____
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____

Applicant may participate in College activities: including sports, physical education and intramurals, nursing activities and responsibilities

☐ Without restriction
☐ With the following restrictions and reason: ____
____

History Reviewed & Student Examined by:

Physician name (print): ___________________________________Signature______________________________
Address____
____ Phone _________________ Fax ________________

NURSING STUDENTS - REQUIRED FORM B – COLLEGE OF SAINT ELIZABETH
START IMMEDIATELY – TIME SENSITIVE REQUIREMENTS!!!

Name____________________________________Class (year)___________DOB________

IMMUNIZATION RECORD

REQUIRED VACCINES – read all instruction documents carefully

Vaccines	Dates Given	College of St. Elizabeth and NJ State Requirements
MMR	#1 ___/ ___/ ___ #2 ___/ ___/ ___ OR Positive Titer Date: ___/ ___/ ___	2 doses or positive titers(must include copy of lab report within **five years**) Minimum of 4 weeks between doses 1st dose given after 1st birthday Option of combined MMR OR 2 individual vaccine doses of measles, mumps, and rubella vaccines.
or Measles	#1 ___ / ___ / ___ #2 ___/ ___ / ___ OR Positive Titer Date: ___/ ___/___	
Mumps	#1 ___ / ___ / ___ #2___ /___ / ___ OR Positive Titer Date ___/___ /___	
Rubella	#1___ /___ / ___ #2___ /___ /___ OR Positive Titer Date: ___ /___ /___	
Meningococcal (resident students)	#1 ___ / ___ / ___ #2 ___ / ___ / ___ ❑ Menomune ❑ Menactra ❑ Menveo	**(WITHIN 5 YEARS)** **<u>All students must read sign and submit meningococcal information sheet</u>**
Hepatitis B	#1 ___/ ___/ ___ #2 ___/ ___/ ___ #3 ___/ ___/___ OR Positive Titer Date: ___/ ___/ ___	3 doses or positive titer (must include copy of lab results) 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
PPD / Mantoux OR Inteferon-gamma release assay tests (IGRA)	PPD ___ / ___ / ___ ___/___/___ result ___mm Planted Read Or Inteferon-gamma release assay tests (IGRA) ___/___/___ ❑ pos. ❑ neg. copy of report 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 <u>mm of induration</u>** **<u>WITHIN ONE YEAR</u>** Must send copy of Inteferon-gamma release assay tests (IGRA) report ***<u>Required by Nutrition and Nursing Departments</u>*** Must send copy of Chest X-Ray report
Tdap or Td Completed primary series	❑Tdap ___/___/___ ❑Td ___/___/___ ❑DTP ❑DT ___/___/___	Booster within last 10 years 1 dose of Tdap recommended ***<u>Required by Nutrition and Nursing Department</u>***
Polio	Primary series: ❑ Oral ❑ Injectable Most recent booster : ___/___/___	Primary series ***<u>Required by Nutrition Department</u>***

_______________________________ _______________________________ ___________

Signature Health Care Provider Print Name Date

College of St. Elizabeth Health Service

Name: ____ DOB ____________

REQUIRED AND RECOMMENDED VACCINES

Vaccines	Dates Given	Recommendations
Varicella (Chicken Pox)	#1 ___/___/___ #2 __ / __ / ___ OR 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 ***Required by Nutrition and Nursing Departments***
HPV (women)	#1___/___/___ #2___/___/___ #3___/___/___	Recommended vaccine Preventative health care recommended

OPTIONAL VACCINES

Vaccines	Dates Given	Recommendations
Hepatitis A	#1 ___/ ___/ ___ #2 ___/ ___/ ___	Recommended if planning to travel and high risk exposure 6-12 months between doses 1 and 2
Pneumococcal	#1 ___/ ___/ ___ ❑ Polysaccharide (PPV) ❑ Conjugate (PCV)	Chronic health problems
Typhoid	#1 ____/____/____	Travel
Hib	___ /____/___	Primary series completed
Yellow Fever	#1 ___/____/ ___	Travel

HEALTH CARE PROVIDER

_______________________________ _______________________________________ ____/____/____
Signature Print Name Date

_________________________________ _________________ _____________ ___________
Address City State Zip

________________________ ________________________
Telephone Fax

Send Records by mail or fax 1 copy to Health Services AND 1copy to Nursing:

College of St. Elizabeth
Health Service – Founders Hall, 2 Convent Road, Morristown, N.J., 07960
Fax: 973 290 4182 Phone 973 290 4175, 4132
Nursing Program - Immunizations, 2 Convent Road, Morristown NJ 07960
Attn. Janet Okken
Fax: 973-290-4177 Phone: 973-290-4139
Any questions, call Immunization Information Line 973-290-4388

MENINGOCOCCAL VACCINES

WHAT YOU NEED TO KNOW

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis.

1 What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of **bacterial meningitis** in children 2 through 18 years old in the United States. Meningitis is an infection of the fluid surrounding the brain and spinal cord.

Meningococcal disease also causes blood infections.

About 1,000 - 2,600 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10-15% of these people die. Of those who survive, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people with certain medical conditions, such as lack of a spleen. College freshmen who live in dormitories, and teenagers 15-19 have an increased risk of getting meningococcal disease.

Meningococcal infections can be treated with drugs such as penicillin. Still, about 1 out of every ten people who get the disease dies from it, and many others are affected for life. This is why *preventing* the disease through use of meningococcal vaccine is important for people at highest risk.

2 Meningococcal vaccine

There are two kinds of meningococcal vaccine in the U.S.:

- **Meningococcal conjugate vaccine (MCV4)** was licensed in 2005. It is the preferred vaccine for people 2 through 55 years of age.
- **Meningococcal polysaccharide vaccine (MPSV4)** has been available since the 1970s. It may be used if MCV4 is not available, and is the only meningococcal vaccine licensed for people older than 55.

Both vaccines can prevent **4 types** of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. Meningococcal vaccines cannot prevent all types of the disease. But they do protect many people who might become sick if they didn't get the vaccine.

Both vaccines work well, and protect about 90% of people who get them. MCV4 is expected to give better, longer-lasting protection.

MCV4 should also be better at preventing the disease from spreading from person to person.

3 Who should get meningococcal vaccine and when?

A dose of MCV4 is recommended for children and adolescents 11 through 18 years of age.

This dose is normally given during the routine pre-adolescent immunization visit (at 11-12 years). But those who did not get the vaccine during this visit should get it at the earliest opportunity.

Meningococcal vaccine is also recommended for other people at increased risk for meningococcal disease:

- College freshmen living in dormitories.
- Microbiologists who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has terminal complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

MCV4 is the preferred vaccine for people 2 through 55 years of age in these risk groups. MPSV4 can be used if MCV4 is not available and for adults over 55.

How Many Doses?

People 2 years of age and older should get 1 dose. Sometimes a second dose is recommended for people who remain at high risk. Ask your provider.

MPSV4 may be recommended for children 3 months to 2 years of age under special circumstances. These children should get 2 doses, 3 months apart.

4 Some people should not get meningococcal vaccine or should wait

- Anyone who has ever had a severe (life-threatening) **allergic reaction to a previous dose** of either meningococcal vaccine should not get another dose.
- Anyone who has a severe (life threatening) **allergy to any vaccine component** should not get the vaccine. Tell your provider if you have any severe allergies.
- Anyone who is **moderately or severely ill** at the time the shot is scheduled should probably wait until they recover. Ask your provider. People with a **mild illness** can usually get the vaccine.
- Anyone who has ever had **Guillain-Barré Syndrome** should talk with their provider before getting MCV4.
- Meningococcal vaccines may be given to pregnant women. However, MCV4 is a new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed.
- Meningococcal vaccines may be given at the same time as other vaccines.

5 What are the risks from meningococcal vaccines?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Mild problems

As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a fever.

Severe problems

- Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.
- A serious nervous system disorder called **Guillain-Barré Syndrome** (or GBS) has been reported among some people who received MCV4. This happens so rarely that it is currently not possible to tell if the vaccine might be a factor. Even if it is, the risk is very small.

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever, weakness, or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

  VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

A federal program exists to help pay for the care of anyone who has had a rare serious reaction to a vaccine.

For information about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's National Immunization Program website at **www.cdc.gov/vaccines**
  - Visit CDC's meningococcal disease website at **www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm**
  - Visit CDC's Travelers' Health website at **wwwn.cdc.gov/travel**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf

REQUIRED FORM C

Meningitis Information Sheet - REQUIRED

Meningococcal Disease Among College Students

(**Read meningitis fact sheet and sign below**)

New Jersey State Law requires all four-year institutions of higher education to:

1) Provide information about meningitis disease and the availability and benefits of a meningitis vaccine to all their full and part-time incoming freshmen, transfer, and graduate students prior to matriculation (please see attached Meningococcal Disease Information Sheet)
2) To record the enrolling student's decision whether or not to receive a meningitis vaccination.
3) The Meningococcal Vaccine is required of all new incoming students who will be residing in campus housing.

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

Complete and Sign all indicated:

Yes ☐ **No** ☐ I have received information about the meningitis disease, (What you need to know – Fact Sheet) the effectiveness of the vaccine, and the availability of a meningitis vaccine.

Yes ☐ **No** ☐ I have received the meningitis vaccine. Date #1 __/__/__ #2 __/__/__

Yes ☐ I am not a residential student and have decided not to receive the meningitis vaccine.

Name ______________________________ Date _________________________

Signature ____

This signature shall become part of the student's health record
And is being required by New Jersey law, P.L. 2000c.25.

Send this required form to:

College of St. Elizabeth
Health Service - Founders Hall
2 Convent Road
Morristown, NJ 07960

Tel (973) 290-4175 or 4132 FAX (973) 290-4182

Any questions, call Immunization Information Line at 973-290-4388

CSE HEALTH SERVICES

REQUEST FORM TO OBTAIN IMMUNIZATION or MEDICAL DOCUMENTS FROM HEALTHCARE PROVIDERS, SCHOOL NURSES, PREVIOUS SCHOOLS/COLLEGES/UNIVERSITIES

To: High School, College, Healthcare Provider, School Nurse
(Please print name/address of provider)

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From: Name of Student / Date of Birth

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Date: ______________________________

Re: Request and Authorization for the Release of: (check all those that are indicated)

☐ Immunization Records ☐Medical Records

I hereby grant permission for the release of my immunization records and/or medical records to Health Services at the College of St. Elizabeth. Please forward my records to:

College of St. Elizabeth

☐ **Nursing Department, 2 Convent Road, Morristown, NJ 07960**
Attention: Janet Okken, Immunizations
Fax: 973-290-4177
Phone: 973-290-4139

☐ **Health Services – Founders Hall,2 Convent Road, Morristown, NJ 07960**
Attention: Madeline Cook, Coordinator, Medical Records
Fax: 973-290-4182
Phone: 973-290-4132 or 4175

Student's Name (Print) ______________________________

Address ______________________________

Telephone Number ____________________ Date of Birth ____________

Signature ______________________________ Date ____________