**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 and send or upload to:** [https://www.cse.edu/meduploads](https://www.cse.edu/meduploads)

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**.
  - Juliene Simpson, Athletic Director, at 973-290-4207 or jsimpson@cse.edu

**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 21 Years old – **Required**
  - All resident students - **Required**
- **Meningitis serogroup B** vaccine – as recommended by 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 Hepislab-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
- **Polio vaccine - Required** Primary series completed

Recommended and Optional Vaccines

- **Meningitis B, Varicella, HPV, Hepatitis A, Flu, 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**

SEND RECORDS BY MAIL, FAX OR UPLOAD TO:

https://www.cse.edu/meduploads or

Health Services – Founders Hall
College of Saint Elizabeth
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@cse.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 CSE Health Services staff due to state and federal privacy laws (HIPAA). They cannot be shared with other College of Saint Elizabeth 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, Accessibility Services Coordinator, at 973-290-4261 or lseneca@cse.edu.

Accessibilities Services  
College of Saint Elizabeth  
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@cse.edu.

Counseling Services  
College of Saint Elizabeth  
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 ____________________________ / / Date of Birth (mm/dd/yyyy)

Last /Maiden name First Middle

Home Address ____________________________

Street City State Zip Code

State/Country of Origin Telephone email

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 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.# ____________________________

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>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name/specialty</th>
<th>Address</th>
<th>City, State</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME: ___________________________</td>
<td>DATE OF BIRTH: ___________________________</td>
<td></td>
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<tr>
<td>-----------------------------------</td>
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</tr>
</tbody>
</table>

**Answer ALL questions  Explain All YES Answers**

### ALLERGY
- Any significant allergy to food, medications, insects, pollen?
  - 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.)

<table>
<thead>
<tr>
<th>RESPIRATORY:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest infection (pneumonia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you smoke cigarettes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many?</td>
<td>How long?</td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SKIN</th>
<th>Any problems with your skin?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Skin rashes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acne</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eczema</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| ENDOCRINE | Thyroid disease |     |    |
|           | Diabetes         |     |    |

<table>
<thead>
<tr>
<th>URINARY</th>
<th>Impaired function of any part of your urinary tract</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Loss of a kidney</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Recurrent urinary infection</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Kidney Infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kidney stones</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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? |     |    |

<table>
<thead>
<tr>
<th>CARDIOVASCULAR:</th>
<th>Heart murmur/ palpitations</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chest pain</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Rheumatic fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High blood pressure</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Irregular heartbeat</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood clots (not menstrual clots)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enlarged heart</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Mitral valve prolapse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fainting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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**

**Name:**

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

<table>
<thead>
<tr>
<th>BONE AND JOINT</th>
<th></th>
<th></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>

<table>
<thead>
<tr>
<th>NEUROLOGY</th>
<th></th>
<th></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>

<table>
<thead>
<tr>
<th>GASTROINTESTINAL</th>
<th></th>
<th></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>Hemia</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>

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

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

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

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

Student Signature: ___________________________ Date: ____/____/_____

History Reviewed by Physician: Signature: ___________________________ Date: ____/____/_____

**Health and Nutrition**

- [ ] Are you following a special diet?
- [ ] Do you have an eating disorder?
- [ ] Unexplained weight loss / gain?

**Reproductive System (men):**

- [ ] Prostate trouble
- [ ] Swelling of the scrotum or testicle
- [ ] Undescended or absent testicle
- [ ] Do you perform testicular self-examination?
- [ ] History of sexually transmitted disease

**Reproductive System (women):**

- [ ] Never had a menstrual period?
- [ ] Any form of menstrual disorder?
- [ ] Do you perform breast self-exam?
- [ ] Last menstrual period _____________
- [ ] Abnormal PAP
- [ ] History of sexually transmitted disease
- [ ] History of pregnancy?

**Accident Prevention**

- [ ] Do you usually wear a seat belt when you ride in car?
- [ ] Do you wear protective equipment when participating in a sports act?
- [ ] Do you drink and drive?

**History & Physical – Updated March 19**
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 _______ Peak Flow (as indicated) ___________

<table>
<thead>
<tr>
<th>System</th>
<th>Satisfactory</th>
<th>Describe Abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose, throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck, thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest, lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen, liver, kidneys, spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphatic’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td></td>
<td></td>
</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>
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<tr>
<td>Psychological</td>
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</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 FORM B – IMMUNIZATION RECORD**
**START IMMEDIATELY – TIME SENSITIVE REQUIREMENTS!**
**COLLEGE OF SAINT ELIZABETH TRADITIONAL UNDERGRADUATE STUDENTS**

Name ___________________________ Class (year) ___________ Date of Birth __/__/_____

### REQUIRED VACCINES

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>College of Saint Elizabeth and NJ State Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR</strong></td>
<td>#1 <strong>/</strong>/__  #2 <strong>/</strong>/__  1st dose given after 1st birthday. Minimum of 4 weeks between doses</td>
<td>2 doses or <strong>positive titers</strong> (must include copy of lab report within five years) Equivocal titers are considered negative</td>
</tr>
<tr>
<td>or Measles</td>
<td>#1 <strong>/</strong>/__  #2 <strong>/</strong>/__  OR Positive Titer Date: <strong>/</strong>/___  <strong>lab report required</strong></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>Mumps</td>
<td>#1 <strong>/</strong>/__  #2 <strong>/</strong>/__  OR Positive Titer Date: <strong>/</strong>/___  <strong>lab report required</strong></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>#1 <strong>/</strong>/__  #2 <strong>/</strong>/__  OR Positive Titer Date: <strong>/</strong>/___  <strong>lab report required</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Meningitis Vaccine</strong> Serogroup ACWY (required) (≥ age 16)</td>
<td>#1 <strong>/</strong>/__  #2 <strong>/</strong>/__  #3 <strong>/</strong>/__  Menomune  Menactra  Menvio</td>
<td><strong>All students ≤ 21 years.</strong>  <strong>All resident students</strong> <em>Final dose must be at or after the age of 16 years old AND within five years of entry</em></td>
</tr>
<tr>
<td><strong>Meningitis Vaccine</strong> Serogroup B (recommended)</td>
<td>#3 <strong>/</strong>/__  #2 <strong>/</strong>/__  #1 <strong>/</strong>/__  Trumenba  Bexsero</td>
<td>As recommended by the CDC  Strong Recommendation</td>
</tr>
<tr>
<td><strong>Meningitis Information Sheet</strong></td>
<td>Meningococcal information sheet fill in, sign, date and submit (Form C)</td>
<td><strong>All students must read sign and submit meningococcal information sheet</strong></td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>#1 <strong>/</strong>/__  #2 <strong>/</strong>/__  #3 <strong>/</strong>/__  OR Positive Titer Date: <strong>/</strong>/___  <strong>lab report required</strong>  Energrix B  Recombivax B  Heplisav B</td>
<td>3 doses or <strong>positive titer</strong> (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</td>
</tr>
<tr>
<td><strong>Interferon-gamma release assay test (IGRA)</strong></td>
<td>Interferon-gamma release assay tests (IGRA) <strong>/</strong>/__  □ pos.  □ neg.  <strong>lab report required</strong></td>
<td>Must send copy of Interferon-gamma release assay tests (IGRA) report</td>
</tr>
<tr>
<td>Or <strong>PPD / Mantoux</strong></td>
<td>Or PPD <strong>/</strong>/__  <strong><strong>/</strong></strong>/____  Read ___ mm  <strong>lab report required</strong></td>
<td>Result must be in: mm of induration  <strong>WITHIN ONE YEAR</strong>  must include planted and read dates</td>
</tr>
<tr>
<td></td>
<td>Positive PPD in past  <strong><strong>/</strong></strong>/____</td>
<td>Must send copy of Chest X-Ray report</td>
</tr>
<tr>
<td></td>
<td>BCG history  <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If PPD or Interferon-gamma release assay tests (IGRA) is positive, chest x-ray is required:  chest x ray  <strong><strong>/</strong></strong>/____  □ normal  □ abnormal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>INH treatment began  <strong><strong>/</strong></strong>/____ completed  <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td><strong>Td</strong></td>
<td>Td  <strong><strong>/</strong></strong>/____</td>
<td><strong>Td 1 dose required</strong>  Td or Tdap within 10 years</td>
</tr>
<tr>
<td><strong>Tdap</strong></td>
<td>Tdap  <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td><strong>DTP</strong></td>
<td>DTP  <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td><strong>DT</strong></td>
<td>DT  <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
<tr>
<td><strong>Polio</strong></td>
<td>Primary series: □ Oral  □ Injectable</td>
<td>Primary series</td>
</tr>
<tr>
<td></td>
<td>Most recent booster:  <strong><strong>/</strong></strong>/____</td>
<td></td>
</tr>
</tbody>
</table>

**Signature**  Health Care Provider  Print Name  Date ___________________________  ___________________________  ___________
**FORM B IMMUNIZATION RECORD**

### 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 / / / #2 / / / OR Positive Titer Date: / / /</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. <strong>Required by Nutrition, PA, and Nursing Departments</strong></td>
</tr>
<tr>
<td>(Chicken Pox)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HPV</strong></td>
<td>#1 / / / #2 / / / #3 / / /</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 / / / #2 / / /</td>
<td>As recommended by the CDC 6-12 months between doses 1 and 2.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pneumococcal</strong></td>
<td>#1 / / /</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>/ / /</td>
<td>Primary series completed</td>
</tr>
<tr>
<td><strong>Flu</strong></td>
<td>/ / /</td>
<td>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 / / /</td>
<td>Travel</td>
</tr>
<tr>
<td><strong>Yellow Fever</strong></td>
<td>#1 / / /</td>
<td>Travel</td>
</tr>
</tbody>
</table>

### HEALTH CARE PROVIDER

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

<table>
<thead>
<tr>
<th>Telephone</th>
<th>Fax</th>
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<tbody>
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</tbody>
</table>

**Send Records by mail, fax or upload to:**
https://www.cse.edu/meduploads
College of Saint Elizabeth
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@cse.edu

TRADITIONAL UNDEGRADUATE STUDENTS - IMMUNIZATION RECORD – REQUIRED FORM B (1-2) Updated June 19
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 College of Saint Elizabeth, all college 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 College of Saint Elizabeth 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.

Send or upload this required form to:
https://www.cse.edu/meduploads

College of Saint Elizabeth
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 June 19
Authorization to Release Medical and Immunization Records to the College of Saint Elizabeth Health Services

Date __________________________________________
Student Name __________________________________________________________
Date of Birth _____ / _____ / ______
Address ____________________________________________________________________________________________
City ______________________________ State ___________________________ Zip Code ______________________
Phone Number ___________ - ____________ - ______________
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 the College of Saint Elizabeth. Please forward my records to:

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

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

Signature/Date ______________________________________________________________________________________
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 disease** is a serious illness caused by a type of bacteria called *Neisseria meningitidis*. It can lead to meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Meningococcal disease often occurs without warning—even among people who are otherwise healthy.

Meningococcal disease can spread from person to person through close contact (coughing or kissing) or lengthy contact, especially among people living in the same household.

There are at least 12 types of *N. meningitidis*, called “serogroups.” Serogroups A, B, C, W, and Y cause most meningococcal disease.

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*
- People at risk because of an outbreak in their community

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, amputations, nervous system problems, or severe scars from skin grafts.

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

**2  Meningococcal ACWY Vaccine**

Meningococcal conjugate vaccine (MenACWY) is licensed by the Food and Drug Administration (FDA) for protection against serogroups A, C, W, and Y.

Two doses of MenACWY are routinely recommended for adolescents 11 through 18 years old: the first dose at 11 or 12 years old, with a booster dose at age 16. Some adolescents, including those with HIV, should get additional doses. Ask your health care provider for more information.

In addition to routine vaccination for adolescents, MenACWY 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 drug called eculizumab (also called Soliris®)
- 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 dormitories
- U.S. military recruits

Some people need multiple doses for adequate protection. Ask your health care provider about the number and timing of doses, and the need for booster doses.
3 Some people should not get this vaccine

Tell the person who is giving you the vaccine if you have any severe, life-threatening allergies. If you have ever had a life-threatening allergic reaction after a previous dose of meningococcal ACWY vaccine, or if you have a severe allergy to any part of this vaccine, you should not get this vaccine. Your provider can tell you about the vaccine’s ingredients.

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 MenACWY vaccination. A pregnant or breastfeeding woman should be vaccinated if she is at increased risk of meningococcal disease.

If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own within a few days, but serious reactions are also possible.

As many as half of the people who get meningococcal ACWY vaccine have mild problems following vaccination, such as redness or soreness where the shot was given. If these problems occur, they usually last for 1 or 2 days.

A small percentage of people who receive the vaccine experience muscle or joint pains.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy or lightheaded, or have vision changes.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

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

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness—usually within a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 and get to the nearest hospital. Otherwise, call your doctor.

Afterward, the reaction should be reported to the “Vaccine Adverse Event Reporting System” (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does 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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider. He or she 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) or
  - Visit CDC’s website at www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
Meningococcal ACWY Vaccines
08/24/2018   |   42 U.S.C. § 300aa-26
Serogroup B Meningococcal Vaccine (MenB): What You Need to Know

1. Why get vaccinated?

**Meningococcal disease** is a serious illness caused by a type of bacteria called *Neisseria meningitidis*. It can lead to meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Meningococcal disease often occurs without warning—even among people who are otherwise healthy.

Meningococcal disease can spread from person to person through close contact (coughing or kissing) or lengthy contact, especially among people living in the same household.

There are at least 12 types of *N. meningitidis*, called “serogroups.” Serogroups A, B, C, W, and Y cause most meningococcal disease.

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*
- People at risk because of an outbreak in their community

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, amputations, nervous system problems, or severe scars from skin grafts.

**Serogroup B meningococcal (MenB) vaccines** can help prevent meningococcal disease caused by serogroup B. Other meningococcal vaccines are recommended to help protect against serogroups A, C, W, and Y.

2. Serogroup B Meningococcal Vaccines

Two serogroup B meningococcal vaccines—Bexsero® and Trumenba®—have been licensed by the Food and Drug Administration (FDA).

These vaccines are recommended routinely for people 10 years or older who are at increased risk for serogroup B meningococcal infections, including:
- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed
- Anyone with a rare immune system condition called “persistent complement component deficiency”
- Anyone taking a drug called eculizumab (also called Soliris®)
- 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.

For best protection, more than 1 dose of a serogroup B meningococcal vaccine is needed. The same vaccine must be used for all doses. Ask your health care provider about the number and timing of doses.

3. Some people should not get these vaccines

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.**
  If you have ever had a life-threatening allergic reaction after a previous dose of serogroup B meningococcal vaccine, or if you have a severe allergy to any part of this vaccine, you should not get the vaccine. **Tell your health care provider if you have any severe allergies that you know of, including a severe allergy to latex.** He or she can tell you about the vaccine’s ingredients.

- **If you are pregnant or breastfeeding.**
  There is not very much information about the potential risks of this vaccine for a pregnant woman or breastfeeding mother. It should be used during pregnancy only if clearly needed.

If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.
Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own within a few days, but serious reactions are also possible.

More than half of the people who get serogroup B meningococcal vaccine have mild problems following vaccination. These reactions can last up to 3 to 7 days, and include:
- Soreness, redness, or swelling where the shot was given
- Tiredness or fatigue
- Headache
- Muscle or joint pain
- Fever or chills
- Nausea or diarrhea

Other problems that could happen after these vaccines:
- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer-lasting than the more routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

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

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

What should I do?

- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 and get to the nearest hospital. Otherwise, call your clinic.

Afterward the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967.

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Vaccine Information Statement
Serogroup B Meningococcal Vaccine

08/09/2016
42 U.S.C. § 300aa-26