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

TIME SENSITIVE REQUIREMENTS

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

ALL HEALTH REQUIREMENTS MUST BE COMPLETED TO ATTEND CLASS

NON-COMPLIANCE WILL LEAD TO FINANCIAL FEES $350, REGISTRATION HOLDS AND INABILITY TO RESIDE IN CAMPUS HOUSING

Complete and send or upload to: 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 Hepislav-B for >18 years old also acceptable
- ***Interferon-gamma release assay tests (IGRA) or PPD /Mantoux testing***
  - **Required within *one year* of entry**
  - ***RESULTS FOR PPD MUST BE IN MM OF INDURATION (record date planted/date read)***
- ***Tdap*** – *1 dose* ***Required***
  - Td or Tdap *within 10 years required*
  - Primary series completed
- ***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, Accessibilities 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(1) Identification

REQUIRED FORM A – HEALTH FORM (4 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 /Maiden name First Middle Date of Birth (mm/dd/yyyy)

Home Address ____
Street City State Zip Code

State/Country of Origin __________Telephone ____________________ ***email*** _______________
home cell

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

CSE Leave Of Absence ____/____ CSE Withdrawal ____/____ CSE 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.# ______________________
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.***

Name/specialty	
Address	
City, State	
Telephone	Fax

Name/specialty	
Address	
City, State	
Telephone	Fax

College of Saint Elizabeth
Health History Questionnaire
Completed by student and physician REQUIRED FORM A(2) history

Name: ______________________________ Date of Birth: ________________________

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

ALLERGY

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

MEDICATIONS:

	Yes	No
Do you take any medications regularly, including herbals, supplements and over the counter drugs?	❑	❑

Medications: List all medications and dosage that you take regularly prescription and non-prescription (ex. Anxiety, ADD, depression, birth control, asthma, diabetes etc.)

HOSPITALIZATION:

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

List:

PAST ILLNESSES

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

ENT

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

CARDIOVASCULAR:

	Yes	No
Heart murmur/ palpitations	❑	❑
Chest pain	❑	❑
Rheumatic fever	❑	❑
High blood pressure	❑	❑
Irregular heartbeat	❑	❑
Blood clots (not menstrual clots)	❑	❑
Enlarged heart	❑	❑
Mitral valve prolapse	❑	❑
Fainting	❑	❑

RESPIRATORY:

	Yes	No
Asthma	❑	❑
Tuberculosis	❑	❑
Chest infection (pneumonia)	❑	❑
Do you smoke cigarettes?	❑	❑
How many? ____ How long? _____		
Shortness of breath	❑	❑
Wheezing	❑	❑
Chronic cough	❑	❑

SKIN

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

ENDOCRINE

	Yes	No
Thyroid disease	❑	❑
Diabetes	❑	❑

URINARY

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

MENTAL HEALTH

	Yes	No
Any problems with your emotional health, requiring any form of therapy, including medications?	❑	❑
Did you ever lie to anyone about your gambling?	❑	❑
Does anyone presently in your life hurt you or make you feel afraid?	❑	❑
History of depression?	❑	❑
History of self harm or harm to others?	❑	❑
History of abuse physically, emotionally or sexually?	❑	❑
Learning disabilities?	❑	❑

DRUG AND ALCOHOL USAGE

	Yes	No
Have you ever felt you should cut down on your drinking?	❑	❑
Have people annoyed you by criticizing your drinking?	❑	❑
Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover?	❑	❑
Smoke cigarettes?	❑	❑

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

REQUIRED FORM A(3) history

Name: ____________________________________

BLOOD:

	Yes	No
Anemia	❑	❑
Sickle-cell disease/trait	❑	❑
Abnormal bleeding or bruising	❑	❑

____
____
____

BONE AND JOINT

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

____
____
____

NEUROLOGY

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

____
____
____

GASTROINTESTINAL

	Yes	No
Problems with any part of your intestinal tract or stomach?	❑	❑
Jaundice/hepatitis/gallbladder disease	❑	❑
Hernia	❑	❑
Ulcer	❑	❑
Acid reflex	❑	❑
Irritable bowel syndrome	❑	❑
Inflammatory bowel disease	❑	❑

____
____

HEALTH AND NUTRITION

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

____
____
____

REPRODUCTIVE SYSTEM (men):

	Yes	No
Prostate trouble	❑	❑
Swelling of the scrotum or testicle	❑	❑
Undescended or absent testicle	❑	❑
Do you perform testicular self-examination?	❑	❑
History of sexually transmitted disease	❑	❑

____
____
____

REPRODUCTIVE SYSTEM (women):

	Yes	No
Never had a menstrual period?	❑	❑
Any form of menstrual disorder?	❑	❑
Do you perform breast self-exam?	❑	❑
Last menstrual period _____________		
Abnormal PAP	❑	❑
History of sexually transmitted disease	❑	❑
History of pregnancy?	❑	❑

____
____
____
____
____

ACCIDENT PREVENTION

	Yes	No
Do you usually wear a seat belt when you ride in car?	❑	❑
Do you wear protective equipment when participating in a sports act?	❑	❑
Do you drink and drive?	❑	❑

Additional Explanations:
____
____
____
____
____
____

<u>FAMILY HISTORY completed by student</u>

Check the following conditions which have appeared in your immediate family, indicating the person's relationship to you. (Ex. Father Cancer)

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

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

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

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

Student Signature: ______________________________print name__________________________ Date: ____/____/_____

<u>History Reviewed by Physician</u>- Signature: ____________________________________ *Date:* ____/____/_____

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) ______________

System	Satisfactory	Describe Abnormality
Eyes		
Ears		
Nose, throat		
Neck, thyroid		
Chest, lungs		
Breast		
Heart		
Abdomen, liver, kidneys, spleen		
Lymphatic's		
Hernia		
Genitalia		
Pelvic (if indicated)		
Rectal		
Extremities, back, spine		
Skin		
Joints		
Neurological		
Psychological		

Laboratory Tests: URINALYSIS ____

BLOOD Cholesterol (Fasting) _______ CBC _______ Sickle Trait Screening and EKG (for athletes) ______

Additional labs as indicated ____

Include copy of lab results

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 **READ ALL INSTRUCTIONS CAREFULLY**

Vaccines	Dates Given	College of Saint Elizabeth 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**
or Measles Mumps Rubella	#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***	Option of combined MMR OR **2** individual vaccine doses of measles, mumps, and rubella vaccines. Single dose vaccines are not manufactured any longer
Meningitis Vaccine Serogroup **ACWY (required)** **(≥ age 16)**	#1 ___ / ___ / ___ **#2 ___ / ___ / ___ *(≥ age 16)*** ❑ **Menomune** ❑ **Menactra** ❑ **Menveo**	**All** students ≤ 21 years. **All** resident students ***Final dose must be at or after the age of 16 years old AND within five years of entry***
Meningitis Vaccine Serogroup **B** (recommended)	#1___/___/___ #2___/___/___ #3___/___/___ ❑**Trumenba** ❑ **Bexsero**	**As recommended by the CDC** **Strong Recommendation**
Meningitis Information Sheet	***Meningococcal information sheet fill in, sign, date and submit (Form C)***	**All students must read sign and submit meningococcal information sheet**
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*
Also **Required** (within the past year) **Interferon-gamma release assay test (IGRA)** **OR** **PPD / Mantoux**	Interferon-gamma release assay tests (IGRA) ___/___/___ ❑ pos. ❑ neg. *lab report required* **Or** PPD ___ /___ /___ ___/___/___ ***result ___mm*** ***Planted*** ***Read*** ***Number*** 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 ___/___/___	Must send copy of Interferon-gamma release assay tests (IGRA) report **Result must be in:** **mm of induration** **WITHIN ONE YEAR** **must include planted and read dates** Must send **copy of Chest X-Ray report**
Tdap Td Completed primary series	❑Tdap ___/___/___ ❑Td ___/___/___ ❑DTP ❑DT ___/___/___	**Tdap 1 dose required** Td or Tdap within 10 years
Polio	Primary series: ❑ Oral ❑ Injectable Most recent booster : ___/___/___	Primary series

Signature Health Care Provider **Print Name** **Date**

_______________________ _______________________ ____________

FORM B IMMUNIZATION RECORD

Name ______________________________ Date of Birth ____/____/____

RECOMMENDED VACCINES

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

OPTIONAL VACCINES

Typhoid	#1 ____/____/____	Travel
Yellow Fever	#1 ___/____/ ___	Travel

HEALTH CARE PROVIDER

______________________ ______________________ ___/___/___
Signature Print Name Date

______________________ ____________ ____________ ____________
Address City State Zip

______________________ ______________________
Telephone Fax

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

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 ☐ 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

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

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

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

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

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

Anyone can get meningococcal disease but certain people are at increased risk, including:

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

2 Meningococcal ACWY vaccine

Adolescents need 2 doses of a meningococcal ACWY vaccine:

- First dose: 11 or 12 year of age
- Second (booster) dose: 16 years of age

In addition to routine vaccination for adolescents, meningococcal ACWY vaccine is also recommended for **certain groups of people**:

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

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of meningococcal ACWY vaccine**, or has any **severe, life-threatening allergies**.

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

Not much is known about the risks of this vaccine for a pregnant woman or breastfeeding mother. However, pregnancy or breastfeeding are not reasons to avoid meningococcal ACWY vaccination. A pregnant or breastfeeding woman should be vaccinated if otherwise indicated.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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

Your health care provider can give you more information.

4 Risks of a vaccine reaction

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

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

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

5 What if there is a serious problem?

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

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

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

6 The National Vaccine Injury Compensation Program

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

7 How can I learn more?

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

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VACCINE INFORMATION STATEMENT

Meningococcal B Vaccine:
What You Need to Know

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

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

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

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

Anyone can get meningococcal disease but certain people are at increased risk, including:

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

2 Meningococcal B vaccine

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

Meningococcal B vaccines are recommended for people 10 years or older who are at increased risk for serogroup B meningococcal disease, including:

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

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

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of meningococcal B vaccine**, or has any **severe, life-threatening allergies**.
- Is **pregnant or breastfeeding**.

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

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

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

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

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

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

5 What if there is a serious problem?

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

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

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

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