COLLEGE OF
Saint Elizabeth

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 to:

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

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* - 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
  - **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 sign 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

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***
- ***Meningococcal vaccine*** – **(serogroup ACWY**) - ***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 for ALL students***
- ***Hepatitis B vaccine*** **– 3 dose series** - ***required***
  - If history of Hepatitis B disease – evidence of immunity is required
  - ***Copy of lab report required for titer***
- ***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***
- ***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, 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 OR FAX TO:

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

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 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.

COLLEGE OF
Saint Elizabeth

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

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:

Do you take any medications regularly, including herbals, supplements and over the counter drugs? ❑ ❑

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

_____
_____
_____

HOSPITALIZATION:

Have you ever been admitted to a hospital?	❑	❑
Have you ever had surgery?	❑	❑
Have you ever had any ER visits?	❑	❑
Have you ever had any severe injury?	❑	❑

List:

_____
_____
_____

PAST ILLNESSES

Hepatitis, mononucleosis, childhood diseases,	❑	❑
HIV	❑	❑
Loss or absence of any body parts.	❑	❑
Severe/frequent colds or flu	❑	❑
Serious illness or injury	❑	❑

_____
_____
_____

ENT

Any problems with your eyes, ears, nose or throat?	❑	❑
Hearing impairment	❑	❑
Loss of eye or eyesight	❑	❑

_____
_____

CARDIOVASCULAR:

Heart murmur/ palpitations	❑	❑
Chest pain	❑	❑
Rheumatic fever	❑	❑
High blood pressure	❑	❑
Irregular heartbeat	❑	❑
Blood clots (not menstrual clots)	❑	❑
Enlarged heart	❑	❑
Mitral valve prolapse	❑	❑
Fainting	❑	❑

_____
_____
_____

RESPIRATORY:

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

_____
_____

SKIN

Any problems with your skin?	❑	❑
Skin rashes	❑	❑
Acne	❑	❑
Eczema	❑	❑

_____ _____
_____

ENDOCRINE

Thyroid disease	❑	❑
Diabetes	❑	❑

_____
_____

URINARY

Impaired function of any part of your urinary tract	❑	❑
Loss of a kidney	❑	❑
Recurrent urinary infection	❑	❑
Kidney Infection	❑	❑
Kidney stones	❑	❑

_____
_____

MENTAL HEALTH

Any problems with your emotional health, requiring any form of therapy, including medications?	❑	❑
Did you ever lie to anyone about your gambling?	❑	❑
Does anyone presently in your life hurt you or make you feel afraid?	❑	❑
History of depression?	❑	❑
History of self harm or harm to others?	❑	❑
History of abuse physically, emotionally or sexually?	❑	❑
Learning disabilities?	❑	❑

_____
_____

DRUG AND ALCOHOL USAGE

Have you ever felt you should cut down on your drinking?	❑	❑
Have people annoyed you by criticizing your drinking?	❑	❑
Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover?	❑	❑
Smoke cigarettes?	❑	❑

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

_____
_____

Name: _____

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

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

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

GASTROINTESTINAL		
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):		
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?	❑	❑

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: _____print name_____ Date: ____/____/_____

History Reviewed by Physician *- 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
COLLEGE OF SAINT ELIZABETH TRADITIONAL UNDERGRADUATE STUDENTS
START IMMEDIATELY – TIME SENSITIVE REQUIREMENTS!

Name_____ Class (year)_____ DOB_____

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** Option of combined MMR OR **2** individual vaccine doses of measles, mumps, and rubella vaccines. Single dose vaccines are not manufactured any longer
or Measles	#1 ___ / ___ / ___ #2 ___/ ___/ ___ **OR Positive Titer Date**: ___/ ___/___***lab report required***	
Mumps	#1 ___ / ___ / ___ #2___ /___ / ___ **OR Positive Titer Date ___/___ /___** ***lab report required***	
Rubella	#1___ /___ / ___ #2___ /___ /___ **OR Positive Titer Date: ___ /___ /__*lab report required***	
Meningococcal Vaccine Serogroup **ACWY** **(≥ age 16)** **Information Sheet**	#1 ___ / ___ / ___ #2 ___ / ___ / ___ ***(≥ age 16)*** ❑ Menomune ❑ Menactra ❑ Menveo ❑ ***Meningococcal information sheet sign and submit***	**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*** **All students must read sign and submit meningococcal information sheet**
Hepatitis B	#1 ___/ ___/ ___ #2 ___/ ___/ ___ #3 ___/ ___/___ OR Positive Titer Date: ___/ ___/ ___ ***lab report required***	**3 doses** or **positive titer** *(must include copy of lab reports)* 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*
Also **Required** **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**

RECOMMENDED VACCINES

Vaccines	Dates Given	Recommendations
Meningitis **Serogroup B**	#1___/___/___ #2___/___/___ #3___/___/___ ❑**Trumenba** ❑ **Bexsero**	As recommended by the CDC Strong Recommendation
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 and Nursing Departments***
HPV (women)	#1___/___/___ #2___/___/___ #3___/___/___ ❑Gardasil ❑Cervarix ❑Gardasill-9	Strong Recommendation Preventative health care
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)13 ❑PPSV 23	Chronic health problems
Hib	___ /____/___	Primary series completed

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 or fax to:

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

VACCINE INFORMATION STATEMENT

Meningococcal ACWY Vaccines — MenACWY and MPSV4: *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 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 vaccines 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 Vaccines

There are two kinds of meningococcal vaccines licensed by the Food and Drug Administration (FDA) for protection against serogroups A, C, W, and Y: meningococcal conjugate vaccine (**MenACWY**) and meningococcal polysaccharide vaccine (**MPSV4**).

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
- 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*
- 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

Children between 2 and 23 months old, and people with certain medical conditions need multiple doses for adequate protection. Ask your health care provider about the number and timing of doses, and the need for booster doses.

MenACWY is the preferred vaccine for people in these groups who are 2 months through 55 years old, have received MenACWY previously, or anticipate requiring multiple doses.

MPSV4 is recommended for adults older than 55 who anticipate requiring only a single dose (travelers, or during community outbreaks).

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

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.

- **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.

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. They are more common after MenACWY than after MPSV4.

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

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 have vision changes or ringing in the ears.
- 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
Meningococcal ACWY Vaccines

03/31/2016

Office Use Only

42 U.S.C. § 300aa-26

VACCINE INFORMATION STATEMENT

Serogroup B Meningococcal Vaccine (MenB): *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 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.

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

4 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**/

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. These would usually start 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 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 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**

REQUIRED FORM # C MENINGITIS INFORMATION SHEET
REQUIRED FOR ALL STUDENTS

COLLEGE OF Saint Elizabeth

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 this required form to:

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 _____-_____-_____ **Student ID** _____

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) _____
Please print

Signature of parent or guardian (If under 18) _____

Relationship to patient _____