



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

**TIME SENSITIVE REQUIREMENTS**

**DEADLINE: IMMEDIATELY prior to JUNE 15<sup>TH</sup> (FALL SEMESTER) DECEMBER 1<sup>ST</sup> (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](mailto: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 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 disability accommodations, **you must** self identify and provide appropriate documentation directly to **Lisa Seneca, Accessibility Services Coordinator, at 973-290-4261 or [lseneca@cse.edu](mailto:lseneca@cse.edu).**

Accessibility Services  
College of Saint Elizabeth  
Mahoney Library  
2 Convent Road  
Morristown, New Jersey 07960

If you have a mental health condition and/or take psychiatric medication and want Counseling Services to be aware of your history, **you must** self-identify and provide appropriate documentation directly to **Zsuzsa A. Nagy, MA, dir.univ., LCSW, Director of Counseling Services, at 973-290-4134 or [znagy@cse.edu](mailto:znagy@cse.edu).**

Counseling Services  
College of Saint Elizabeth  
Wellness Center  
2 Convent Road  
Morristown, New Jersey 07960

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



**REQUIRED FORM A – HEALTH FORM (4 PAGES) – 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*

<b>ALLERGY</b>	<b>Yes</b>	<b>No</b>
Any significant allergy to food, medications, insects, pollen?	<input type="checkbox"/>	<input type="checkbox"/>
List known allergies and type of reaction to them:		
Medication.....	<input type="checkbox"/>	<input type="checkbox"/>
Food.....	<input type="checkbox"/>	<input type="checkbox"/>
Environmental.....	<input type="checkbox"/>	<input type="checkbox"/>
Vaccines.....	<input type="checkbox"/>	<input type="checkbox"/>

**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	<input type="checkbox"/>	<input type="checkbox"/>
Loss or absence of any body parts.	<input type="checkbox"/>	<input type="checkbox"/>
Severe/frequent colds or flu	<input type="checkbox"/>	<input type="checkbox"/>
Serious illness or injury	<input type="checkbox"/>	<input type="checkbox"/>

**ENT**

Any problems with your eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>
Loss of eye or eyesight	<input type="checkbox"/>	<input type="checkbox"/>

**CARDIOVASCULAR:**

Heart murmur/ palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots (not menstrual clots)	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged heart	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>

**RESPIRATORY:**

	<b>Yes</b>	<b>No</b>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest infection (pneumonia)	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
How many? _____ How long? _____		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>

**SKIN**

Any problems with your skin?	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>

**ENDOCRINE**

Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

**URINARY**

Impaired function of any part of your urinary tract	<input type="checkbox"/>	<input type="checkbox"/>
Loss of a kidney	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent urinary infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>

**MENTAL HEALTH**

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

**DRUG AND ALCOHOL USAGE**

Have you ever felt you should cut down on your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have people annoyed you by criticizing your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>
Smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>

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

Name: \_\_\_\_\_

<b>BLOOD:</b>	<b>Yes</b>	<b>No</b>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Sickle-cell disease/trait	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>

**BONE AND JOINT**

Any serious disability, deformity or disease of bone, joint, or muscle?	<input type="checkbox"/>	<input type="checkbox"/>
Injury, neck, shoulder, back, knee, ankle, other	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

**NEUROLOGY**

Concussion/head injury	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>

**GASTROINTESTINAL**

Problems with any part of your intestinal tract or stomach?	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice/hepatitis/gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflex	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>

*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	_____ 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 \_\_\_\_\_

**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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**HEALTH AND NUTRITION**

	<b>Yes</b>	<b>No</b>
Are you following a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss / gain?	<input type="checkbox"/>	<input type="checkbox"/>

**REPRODUCTIVE SYSTEM (men):**

Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the scrotum or testicle	<input type="checkbox"/>	<input type="checkbox"/>
Undescended or absent testicle	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform testicular self-examination?	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>

**REPRODUCTIVE SYSTEM (women):**

Never had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
Any form of menstrual disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform breast self-exam?	<input type="checkbox"/>	<input type="checkbox"/>
Last menstrual period _____		
Abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
History of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>

**ACCIDENT PREVENTION**

Do you usually wear a seat belt when you ride in car?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear protective equipment when participating in a sports act?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink and drive?	<input type="checkbox"/>	<input type="checkbox"/>

## 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)

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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
<b>MMR</b>	#1 ___/___/___ #2 ___/___/___  1 <sup>st</sup> dose given after 1 <sup>st</sup> birthday. Minimum of 4 weeks between doses	<b>2</b> doses or <b>positive titers</b> <i>(must include copy of lab report within five years)</i> Equivocal titers are considered negative  Option of combined MMR OR <b>2</b> individual vaccine doses of measles, mumps, and rubella vaccines.  Single dose vaccines are not manufactured any longer
<b>or</b> Measles	#1 ___/___/___ #2 ___/___/___ <b>OR Positive Titer Date:</b> ___/___/___ <i>lab report required</i>	
Mumps	#1 ___/___/___ #2 ___/___/___ <b>OR Positive Titer Date</b> ___/___/___ <i>lab report required</i>	
Rubella	#1 ___/___/___ #2 ___/___/___ <b>OR Positive Titer Date:</b> ___/___/___ <i>lab report required</i>	
<b>Meningococcal Vaccine</b> Serogroup ACWY (≥ age 16)  <b>Information Sheet</b>	#1 ___/___/___ #2 ___/___/___ (≥ age 16) <input type="checkbox"/> Menomune <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo  <input type="checkbox"/> <i>Meningococcal information sheet sign and submit</i>	<b>All</b> students ≤ 21 years. <b>All</b> resident students <b>Final dose must be at or after the age of 16 years old AND within five years of entry</b>  <b>All students must read sign and submit meningococcal information sheet</b>
<b>Hepatitis B</b>	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___  OR Positive Titer Date: ___/___/___ <i>lab report required</i>	<b>3 doses</b> or <b>positive titer</b> <i>(must include copy of lab reports)</i> Minimum of <b>4 weeks</b> between doses 1 and 2 Minimum of <b>8 weeks</b> between doses 2 and 3 Minimum of <b>16 weeks</b> between doses 1 and 3
<b>Also Required Interferon-gamma release assay test (IGRA)</b>  <b>OR</b> <b>PPD / Mantoux</b>	Interferon-gamma release assay tests (IGRA) ___/___/___ <input type="checkbox"/> pos. <input type="checkbox"/> neg. <b>lab report required</b>  Or PPD ___/___/___ <b>Planted</b> ___/___/___ <b>Read</b> <b>result</b> ___ <b>mm</b> <b>Number</b>  Positive PPD in past BCG history ___/___/___ If PPD or Interferon-gamma release assay tests (IGRA) is positive, chest x-ray is required: <b>chest x ray</b> ___/___/___ <input type="checkbox"/> normal <input type="checkbox"/> abnormal  INH treatment began ___/___/___ completed ___/___/___	Must send copy of Interferon-gamma release assay tests (IGRA) report  <b>Result must be in:</b> <b>mm of induration</b> <b>WITHIN ONE YEAR</b> <b>must include planted and read dates</b>  Must send <b>copy of Chest X-Ray report</b>
<b>Tdap</b> Td Completed primary series	<input type="checkbox"/> Tdap ___/___/___ <input type="checkbox"/> Td ___/___/___ <input type="checkbox"/> DTP <input type="checkbox"/> DT ___/___/___	<b>Tdap 1 dose required</b> Td or Tdap within 10 years
<b>Polio</b>	Primary series: <input type="checkbox"/> Oral <input type="checkbox"/> Injectable  Most recent booster : ___/___/___	Primary series

Signature Health Care Provider

Print Name

Date



**RECOMMENDED VACCINES**

Vaccines	Dates Given	Recommendations
<b>Meningitis Serogroup B</b>	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero	As recommended by the CDC Strong Recommendation
<b>Varicella (Chicken Pox)</b>	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___  History of disease <input type="checkbox"/> No <input type="checkbox"/> 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  <b><u>Required by Nutrition and Nursing Departments</u></b>
HPV (women)	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ <input type="checkbox"/> Gardasil <input type="checkbox"/> Cervarix <input type="checkbox"/> Gardasil-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 ___/___/___ <input type="checkbox"/> Polysaccharide (PPV) <input type="checkbox"/> Conjugate (PCV)13 <input type="checkbox"/> 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***

# 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](http://www.immunize.org/vis)

Hojas de Información Sobre Vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://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).



**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/](http://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](http://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](http://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](http://www.cdc.gov/vaccines)

**Vaccine Information Statement  
Meningococcal ACWY Vaccines**

03/31/2016

42 U.S.C. § 300aa-26

Office Use Only



# 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](http://www.immunize.org/vis)

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



## 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/](http://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](http://www.vaers.hhs.gov), or by calling **1-800-822-7967**.

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- Call your local or state health department.
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## Vaccine Information Statement Serogroup B Meningococcal Vaccine

08/09/2016

42 U.S.C. § 300aa-26

Office Use Only



**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 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 \_\_\_\_\_