Saint Elizabeth University

Graduate and Continuing Studies

State of NJ and Saint Elizabeth University Medical Requirements

TIME SENSITIVE REQUIREMENTS

DEADLINE: IMMEDIATELY

FALL SEMESTER – DUE JULY 1ST or immediately upon enrollment

SPRING SEMESTER – DUE DECEMBER 1ST or immediately upon enrollment

ALL HEALTH REQUIREMENTS MUST BE COMPLETED TO ATTEND CLASS

NON-COMPLIANCE WILL LEAD TO FINANCIAL FEES $350 AND REGISTRATION HOLDS

Complete and upload to: https://www.steu.edu/meduploads or mail

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 the physician completes all medical information, which can be mailed or faxed to Health Services. **READ and FOLLOW ALL INSTRUCTIONS CAREFULLY**

- ❑ ***REQUIRED FORM #1 - HEALTH FORM***
  - ***Identification Data (include maiden name, if appropriate)***
  - ***Emergency Information***

- ❑ ***REQUIRED FORM #2 – IMMUNIZATION RECORD***
  - ***Physician to complete and sign***
  - ***All students must fulfill the vaccine requirements prior to entrance***

- ❑ ***REQUIRED FORM #3 – MENINGITIS INFORMATION SHEET***
  - ***All students must read the information about meningitis & the vaccine***
  - ***All students must sign and submit the meningitis information sheet***

- ❑ **RECOMMENDED FORM #4 – HISTORY & PHYSICAL FORM**
  - **Physician to complete and sign**
  - **Strongly recommended but not required**
  - **History and Physical within one year of entrance**

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 by your physician or health care provider.*

PLEASE NOTE: **Nursing, Foods and Nutrition, Psychology, Physician Assistant, Education Departments** require additional health information. Please contact these departments for further instructions. Nursing forms are available on the SEU website. All ***RESIDENT STUDENTS*** must complete the ***Traditional Undergraduate Medical Requirements and forms***.

Start Immediately. Time Sensitive Requirements!

Immunization Requirements

- **MMR vaccines** - **REQUIRED**
  2 doses MMR or 2 measles, 2 mumps, 2 rubella or evidence of immunity
  - Required of all students born after 1956+
  - First dose must be ***after the 1st birthday and vaccines are acceptable after 1968***
  - Between the **two MMR** doses, a minimum of **28 days is required.**
  - Single dose vaccines are not manufactured any longer.
  - **Copy of lab** report for immunity done within **5 years**
    - ***Be aware! DO NOT ASSUME PRESENT IMMUNITY*** *if you do not have a record of 2 MMR's*
    - *Equivocal titers are considered negative*

- **Hepatitis B vaccines - REQUIRED** for all students with 12 or more credits (recommended for others)
  3 dose series for Recombivax (Merck) or Engerix-B (GSK)
  Or 2 dose series with Heplisav-B (recombinant, adjuvanted)
  - Minimum of 4 weeks between doses 1 and 2 (for 2 and 3 dose series)
  - Minimum of 8 weeks between doses 2 and 3 (for 3 dose series)
  - Minimum of 16 weeks between doses 1 and 3 (for 3 dose series)

  Or Evidence of immunity
  - **Copy of lab** report required for immunity

- **Meningitis Information Sheet** – **REQUIRED**
  - meningitis vaccines as per CDC guidelines

- **COVID 19 vaccines – REQUIRED** as per CDC and ACIP **Must be fully vaccinated and boostered to register**

Recommended and Optional Vaccine

- **Tdap, Flu, Varicella, HPV, Hepatitis A, Meningitis ACWY and B, Pneumococcal, HiB, Polio, Typhoid, Zoster, Yellow Fever**

The history and physical, recommended and optional vaccines are not required. To promote preventive Healthcare and management the physical and vaccines should be discussed with your physician.

Without the above COMPLETE documented health records and required immunizations you will INCUR FINANCIAL FEES $350, REGISTRATION HOLDS AND CLASS ATTENDANCE DELAYS

COMPLETED RECORDS MUST BE RECEIVED **IMMEDIATELY**
FALL SEMESTER - DUE July 1st **SPRING SEMESTER - Due December 1st**
Upload Records to: https://www.steu.edu/meduploads
Health Services - Founders Hall
Saint Elizabeth University
2 Convent Road
Morristown, NJ, 07960
PHONE: 973-290-4132 **FAX:** 973-290-4182
Any questions, please call Immunization Information Line: 973-290-4388 ext 4388
immunization@steu.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 medical records that you and your physician complete will be accessible **only to SEU Health Services staff** due to state and federal privacy laws (HIPAA). They cannot be shared with any Saint Elizabeth University departments without proper permission as required by law.

If you require accessibility accommodations, **you must** self identify and provide appropriate documentation directly to the Accessibility Services Coordinator.

Accessibility Services - Saint Elizabeth University
Mahoney Library - 2 Convent Road
Morristown, New Jersey 07690
Phone: 973-290-4261
Email address: lseneca@steu.edu

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 the appropriate documentation directly to the Director of Counseling Services.

Zsuzsa A. Nagy, MA, dr.univ., LCSW Director of Counseling Services
Counseling Services - Saint Elizabeth University
Founders Hall - 2 Convent Road
Morristown, New Jersey 07690
Phone: 973-290-4134
Email address: znagy@steu.edu

Should you choose to sign a release of information form, the above service areas can coordinate your care. For further details or questions, please contact the individual offices.

Saint Elizabeth University
MORRISTOWN, NJ

REQUIRED FORM #1 – HEALTH FORM Identification Graduate /Continuing Studies

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 ext 4388

IDENTIFICATION DATA

Name _____ _____/____/_____
Last /Maiden name First Middle Date of Birth

Home Address _____
Street City State Zip Code

Country of Origin _____Telephone ____ ____ __ _____/_ __ _ _____
cell home

Email _____@_____

Program/Degree_____ Credits#_____ First Semester Enrolled ___/___ Expected Graduation Date ___/___
MM/YY MM/YY

Freshman ____ Transfer ____SEU Leave of Absence ____/____ SEU Withdrawal ____/____ SEU Dismissal ____/____
MM/YY MM/YY MM/YY

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.# _____

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

REQUIRED FORM #2 (A) IMMUNIZATION RECORD GRADUATE AND CONTINUING STUDIES

Start Immediately-Time Sensitive Requirements

Name_____ Class (year)_____ DOB_____/_____/_____

REQUIRED VACCINES **Read all instruction documents carefully**

Vaccines	Dates Given	Saint Elizabeth University and NJ State Requirements
MMR	#**1 ___/ ___/ ___ #2 ___/ ___/ ___** Minimum of **4** weeks between doses **1st** dose given after **1st** birthday	Option of combined ***2 MMR***
Or Measles Mumps Rubella	#1 ___ / ___ / ___ #2 ___/ ___ / ___ OR Positive Titer Date: ___/ ___/___ ***copy of lab report*** **REQUIRED** within **5** years #1 ___ / ___ / ___ #2___ /___ / ___ OR Positive Titer Date ___/___ /___ ***copy of lab report*** **REQUIRED** within **5** years #1___ /___ / ___ #2___ /___ /___ OR Positive Titer Date: ___ /___ /___ ***copy of lab report*** **REQUIRED** within **5** years	*or* ***2 individual measles, mumps, rubella vaccines Vaccines must be after 1968 and after 1st birthday*** or **Positive Titers** within **5** years copy of lab report required DO NOT ASSUME PRESENT IMMUNITY *Equivocal titers are considered negative* Single dose vaccines are not manufactured any longer
Meningitis Serogroup ACWY	**#1 ___ / ___ / ___ #2 ___ / ___ / ___** ❑ **Menomune** ❑ **Menactra** ❑ **Menveo**	Final Dose must be at or after the age of 16 years old AND within 5 years of entry , ≤ 23years old) **required for all resident students** further recommendations as per CDC
Meningitis information sheet	❑ **All students must read sign and submit meningitis information sheet**	**All students** must read sign and submit meningitis information sheet.
Meningitis Serogroup B	#1 ___/ ___/ ___ #2 ___/ ___/ ___ #3 ___/ ___/___ ❑ **Trumenba** ❑ **Bexsero**	≤ 23years old , further recommendations as per the CDC
Hepatitis B **Required for students with 12 or more credits** (Recommended for all others)	#1 ___/ ___/ ___ #2 ___/ ___/ ___ #3 ___/___/___ OR Positive Titer Date: ___/ ___/ ___ **copy of lab report REQUIRED** □ **Engerix B** □ **Recombivax B** □ **Heplisav B**	3 doses Engerix B/ Recombivax B Or 2 doses Heplisav B Or positive titer (must include copy of lab results) Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 Minimum of 16 weeks between doses 1 and 3 ***Required for Nutrition, Nursing, PA and Residents***
COVID 19	#1___/____/___ #2___/___/___#3___/___/___ □Pfizer □ Moderna □ Johnson and Johnson other_____	As per CDC and ACIP **Must be up to date to register(primary series and boosters)**
RECOMMENDED VACCINES		
Flu	#1 ___/____/ ___	Yearly seasonal, as per the CDC
Inteferon-Gamma Release Assay tests (IGRA) Or PPD / Mantoux Healthcare	Inteferon-gamma release assay tests (IGRA) ___/___/___ ❑ pos. ❑ neg. copy of report 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 Inteferon-gamma release assay tests (IGRA) report **Result must be in mm of induration WITHIN ONE YEAR** ***Required for Nutrition, Nursing, PA and Residents*** Must send copy of Chest X-Ray report

Health care Provider Signature_____Date_____

RECOMMENDED VACCINES #2(B) **Name**_____

Vaccines	Dates Given	Recommendations
Tdap Td Completed primary series	❑Tdap ___/___/___ ❑Td ___/___/___ ❑DTP ❑DT ___/___/___	Tdap or Td Booster within last 10 years 1 dose of Tdap ***Required for Nutrition, Nursing, PA and Residents***
Polio	Primary series: ❑ Oral ❑ Injectable Most recent booster : ___/___/___	Primary series, boosters as per CDC ***Required for Nutrition, Nursing, PA and Residents***
Varicella (Chicken pox)	#1 ___/___/___ #2 __ / __ / ___ OR Positive Titer Date: ___ / ___/ ___ History of disease ❑No ❑Yes Date ____ / ___	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, PA Departments***
HPV	#1___/___/___ #2___/___/___ #3___/___/___	Preventative health care, as per the CDC
Hib	___/___/___	Primary series completed, as per the CDC
Hepatitis A	#1 ___/ ___/ ___ #2 ___/ ___/ ___	As per the CDC 6-12 months between doses 1 and 2
Pneumococcal	___/ ___/ ___ ___/ ___/ ___ ❑Polysaccharide (PPV) ❑Conjugate (PCV)	As per the CDC Chronic health problems
Zoster	___/___/___ ___/___/___	As per the CDC

OPTIONAL VACCINES

Typhoid	___/____/___	Travel as per the CDC
Yellow Fever	#1 ___/____/ ___	Travel as per the CDC

HEALTH CARE PROVIDER

_____ _____ ___/___/___

Signature ***Print Name*** ***Date***

_____ _____ _____ _____

Address City State Zip

_____ _____

Telephone Fax

Upload your records : https://www.steu.edu/meduploads

Or fax or mail *Saint Elizabeth University, 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 or immunization@steu.edu

REQUIRED FORM #3 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 Saint Elizabeth University, all college students must complete and return this form to the address below.

1) The University 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 University 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 Saint Elizabeth University 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.steu.edu/meduploads**

Saint Elizabeth University
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 ext 4388

immunization@steu.edu

Authorization to Release Medical and Immunization Records to the Saint Elizabeth University Health Services

Saint Elizabeth University
MORRISTOWN, NJ

Date _____

Student Name _____

Date of Birth _____ / _____ / _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ - _____ - _____

I request and authorize (High School, University, Healthcare Provider, School Nurse)

_____

to release (check all those that are indicated)

❑ Immunization Records ❑ Medical Records

to Health Services at Saint Elizabeth University. Please forward my records to:

Saint Elizabeth University
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 _____

VACCINE INFORMATION STATEMENT

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.

Meningococcal disease is rare and has declined in the United States since the 1990s. However, it is a severe disease with a significant risk of death or lasting disabilities in people who get it.

Anyone can get meningococcal disease. 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 "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 who have not been completely vaccinated with meningococcal ACWY vaccine
- U.S. military recruits

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

3. Talk with your health care provider

Tell your vaccination 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 until a future visit.

There is limited information on the risks of this vaccine for pregnant or breastfeeding people, but no safety concerns have been identified. A pregnant or breastfeeding person should be vaccinated if indicated.

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 vaccination.
- A small percentage of people who receive meningococcal ACWY vaccine experience muscle pain, headache, or tiredness.

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 members 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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. 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.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- 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**.

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.

Meningococcal disease is rare and has declined in the United States since the 1990s. However, it is a severe disease with a significant risk of death or lasting disabilities in people who get it.

Anyone can get meningococcal disease. 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 "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, based on discussions between the patient and health care provider. The preferred age for vaccination is 16 through 18 years.

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

3. Talk with your health care provider

Tell your vaccination 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 until a future visit.

Meningococcal B vaccination should be postponed for pregnant people unless the person is at increased risk and, after consultation with their health care provider, the benefits of vaccination are considered to outweigh the potential risks.

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.

4. Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given, tiredness, headache, muscle or joint pain, fever, or nausea can happen after meningococcal B vaccination. 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 members do not give medical advice.*

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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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. 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.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- 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**.

Saint Elizabeth University
Health History Questionnaire
Completed by student and physician **FORM (4(A)-recommended) 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:

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*** _____