

Dear Entering NJMS Student,

The attached health documentation is required for matriculation as per University Policy and is for your protection as well as the protection of patients and staff. All UMDNJ policies are based upon the Centers for Disease Control (CDC) recommendations for healthcare workers, including students.

NOW:

- Read through all forms in this packet
- Review the “Student Immunization & Health Requirements Policy”
http://www.umdj.edu/opmweb/university_policies/student_affairs/PDF/00-01-25-40_00.pdf
- **Schedule** an appointment with your healthcare provider for a complete history and physical and completion of the **Immunization Record. Must be on UMDNJ forms.**
- Give the **Healthcare Provider Checklist** to your healthcare provider

NEXT:

- Submit the completed **Health History and Physical Exam** form
- Submit the completed **Immunization Record** (no other forms will be accepted)
- Submit copies of any required lab reports (titers, chest-x-ray if necessary)
- Complete and return the **Meningococcal Meningitis Response Form**
- Obtain a “**two step**” PPD or an FDA approved blood essay for TB (such as Quantiferon Gold) as indicated on the **Immunization Record**
This consists of two PPD tests placed approx. 1-3 weeks apart. Each test must be read 48-72 hours after placement.
- If you are planning to apply for on-campus residence, you will need to provide proof of meningococcal vaccination (Menactra) for your housing application to be processed

All of these pre-matriculation requirements are due by April 1, 2012.

Please make sure to have your health care provider complete, sign and date all forms. Give the **Healthcare Provider Checklist** to your healthcare provider so that the appropriate tests are performed. Your provider may not be familiar with some of these requirements, but they are, in fact, **REQUIRED**. The checklist may help to avoid the wrong tests being ordered at an increased cost to you, as any cost incurred related to the above requirements is your responsibility. The healthcare provider checklist is NOT to be returned to Student Health Services.

If you have any questions or require additional information, please contact the Student Health Services at: **973-972-7687**.

Please mail or FAX the completed forms to:

**UMDNJ/Student Health Services
90 Bergen Street
Doctor’s Office Center, Suite 1750
Newark, NJ 07103-2499
FAX: 973-972-0018**

Sincerely,

Robin Schroeder, MD
Medical Director

Revised
12/20/11

MAIL OR FAX TO:

UMDNJ – Student Health Services
90 Bergen Street - DOC Suite 1750
Newark, NJ 07103
Phone: (973) 972-7687
Fax: (973) 972-0018

IMMUNIZATION RECORD (CONTINUED)

Name _____

Last

First

Cell # _____

H. Hepatitis B

At least one of three doses is required prior to the enrollment:

Dose #1 / /
M D Y

Dose #2 / /
M D Y

Dose #3 / /
M D Y

H

I. Hepatitis B Surface Antibody Titer – Titer must be QUANTITATIVE not qualitative

Required 1–2 months after dose #3 (attach lab report)..... / /
M D Y

I

J and K are required, regardless of vaccination history

J. Hepatitis B Core antibody must be Total (attach lab report)..... / /
M D Y

K. Hepatitis B Surface antigen (attach lab report)..... M D / /
Y

K

If K is positive, additional testing will be required

L. Meningococcal vaccine (required for UMDNJ housing application processing)

 / /
M D Y

L

M. Complete Meningococcal Meningitis Response Form (separate form,-attach)

M

N. Health History & Physical (attach UMDNJ FORM) / /
M D Y

N

Health Services Only	
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HEALTH CARE PROVIDER (must be completed):

Print Name _____ Address _____

Signature _____

Date _____ Phone () _____

Fax () _____

Meningococcal Vaccines

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 <http://www.immunize.org/vis>

1

What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,000 – 1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10-15% of these people die. Of those who live, another 11%-19% lose their arms or legs, have problems with their nervous systems, become deaf or mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16-21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

2

Meningococcal vaccine

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (**MCV4**) is the preferred vaccine for people 55 years of age and younger.
- Meningococcal polysaccharide vaccine (**MPSV4**) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

3

Who should get meningococcal vaccine and when?

Routine Vaccination

Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16.

Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

Other People at Increased Risk

- College freshmen living in dormitories.
- Laboratory personnel who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has persistent complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

Children between 9 and 23 months of age, and anyone else with certain medical conditions need 2 doses for adequate protection. Ask your doctor about the number and timing of doses, and the need for booster doses.

MCV4 is the preferred vaccine for people in these groups who are 9 months through 55 years of age. MPSV4 can be used for adults older than 55.



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

4**Some people should not get meningococcal vaccine or should wait.**

- Anyone who has ever had a severe (life-threatening) allergic reaction to a previous dose of MCV4 or MPSV4 vaccine should not get another dose of either vaccine.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. *Tell your doctor if you have any severe allergies.*
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Meningococcal vaccines may be given to pregnant women. MCV4 is a fairly new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed. The manufacturers of MCV4 maintain pregnancy registries for women who are vaccinated while pregnant.

Except for children with sickle cell disease or without a working spleen, meningococcal vaccines may be given at the same time as other vaccines.

5**What are the risks from meningococcal vaccines?**

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Brief fainting spells and related symptoms (such as jerking or seizure-like movements) can follow a vaccination. They happen most often with adolescents, and they can result in falls and injuries.

Sitting or lying down for about 15 minutes after getting the shot – especially if you feel faint – can help prevent these injuries.

Mild problems

As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

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

Severe problems

Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.

6**What if there is a moderate or severe reaction?****What should I look for?**

Any unusual condition, such as a severe allergic reaction or a high fever. If a severe allergic reaction occurred, it would be within a few minutes to an hour after the shot. Signs of a serious allergic reaction can include **difficulty breathing, weakness, hoarseness or wheezing, a fast heart beat, hives, dizziness, paleness, or swelling of the throat.**

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your provider to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS website at www.vaers.hhs.gov, or by calling **1-800-822-7967**.

VAERS does not provide medical advice.

7**The National Vaccine Injury Compensation Program**

The National Vaccine Injury Compensation Program (VICP) was created in 1986.

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.

8**How can I learn more?**

- Your doctor can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-4636 (1-800-CDC-INFO)** or
 - Visit CDC's website at www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
Meningococcal Vaccines

10/14/2011

42 U.S.C. § 300aa-26



Meningococcal Vaccine Form

Student Name: _____ **Date of Birth:** _____

(Last) (First)

UMDNJ School: GSBS NJDS NJMS SHRP SN SPH OTHER

MENINGOCOCCAL VACCINATION IS REQUIRED FOR ALL STUDENTS RESIDING IN THE UNIVERSITY RESIDENCE HALL:

- The State of New Jersey requires that all students residing in a campus dormitory (residence hall) receive a meningococcal vaccination as a condition of attendance at that institution
- UMDNJ policy states that, “Students residing in University student housing must receive or have proof of having received one dose of meningococcal vaccine.”
- The Centers for Disease Control (CDC) recommend routine vaccination for persons age 19-55 who are at increased risk for meningococcal disease, such as students living in dormitories.

		For office use only	
<u>Meningococcal vaccination</u>	<u>Date given</u>	<u>review #1</u>	<u>review #2</u>
(MCV4) tetravalent conjugate (Menactra™ within 5 years of matriculation)	____/____/____ <small>mm dd yy</small>		

Healthcare provider information:

Print Name _____

Address _____

Phone _____

Signature _____

Date _____

Return form to:

UMDNJ/Office on Housing
 30 Bergen Street, ADMC 301
 Newark, NJ 07101
 973-972-4540 (Fax)

UMDNJ/Student Health Services

90 Bergen Street
DOC Suite 1750
Newark, NJ 07103-2499
Phone: (973) 972-7687
Fax: (973) 972-0018

Health History

(To be completed by the student. Please print or type)

Name: _____ School/ Grad Year _____
 (Last) (First) (MI) (NJMS, NJDS, GSBS, SHRP, SN, SPH, VISITING)

Date of Birth: ____ / ____ / ____ Male Female If SHRP or SN: _____
 mo day year (Program)

Permanent Address _____
 Street & Apt # City State Zip code

Contact Telephone(Cell): _____ E-mail: _____

Emergency Contact: _____
 Name Relationship Telephone

Describe your usual health: Excellent Good Fair Poor
 How often do you exercise a week? Never 1-2 times 3-5 times >5 times
 How much tobacco do you use? None <1/2 PPD 1/2 - 1 PPD >1 PPD Other
 How many alcoholic drinks do you have a week? None 1-3/wk 4-6/wk 7+/wk
 Do you have any ongoing health problems? Yes No If yes, specify diagnosis & date(s): _____

Have you ever had surgery? Yes No If yes, specify procedure(s) and date(s): _____

Any hospitalizations not specified above? Yes No If yes, specify reasons(s) and date(s): _____

Have you ever received treatment for anxiety, depression, eating disorders, alcohol or other substance abuse, or any other emotional/psychiatric problem? Yes No If yes, specify diagnosis and date(s): _____

Please specify any allergies to medications, latex, and other substances (include reaction). If none, write none: _____

Please list any medications you take regularly. Include all prescription medications, contraceptives, non-prescription medications, vitamins, herbs, supplements, and homeopathic remedies: _____

Has your activity been restricted in the past 5 years? Yes No If yes, specify reason(s) and date(s): _____

Name: _____ School/Year/Program: _____
 (Last) (First) (MI) (NJMS, NJDS, GSBS, SHRP, SPH, SN, VISITING)

Health History (continued)

Is there a family (parents, siblings, grandparents) history of:

Hypertension Yes No Who: _____
 Heart Disease Yes No Who: _____
 Diabetes Yes No Who: _____
 Cancer Yes No Who: _____
 Psychiatric Yes No Who: _____

High Cholesterol Yes No Who: _____
 Stroke Yes No Who: _____
 Alcoholism Yes No Who: _____
 Type: _____
 Type: _____

For women: Have you had a regular gynecological exam and Pap smear? Yes No

I CERTIFY THAT THE ABOVE IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

Patient Signature _____

Date _____

Contents of Student Health Services student records may be disclosed to other persons or offices if considered necessary by the Service for the health or safety of any individual(s) or to consider the student's ability to fulfill the Essential Functions of the educational program.

Any disclosure made to Student Health Services on this form or in any other manner does not constitute notice to UMDNJ of a disability or handicap and will not be considered a request for accommodations. All requests for reasonable accommodations must be made directly to the UMDNJ School in which the student is enrolled, in accordance with the procedures of the school.

PHYSICAL EXAM

(Must be completed by a non-relative physician, nurse practitioner, or physician's assistant)

Physical Exam Date: _____

Visual Acuity (with correction, if any): OD _____ OS _____ Correction? Yes No
 Height (inches) _____ Weight (pounds) _____ BMI _____ BP _____ Pulse _____

	Normal	Abnormal	Not Done	If abnormal, please explain:
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (scars, tatoos)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pelvic Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GU Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does this student require ongoing medical care? Yes No Specify: _____

HEATH CARE PROVIDER (must be completed): Address: _____

Print Name: _____

Signature _____ Phone: _____

Date _____ Fax: _____