



SCHOOL OF NURSING

University of Medicine & Dentistry of New Jersey

NEWARK CAMPUS

March 27, 2009

Dear Entering SN Student,

The attached health documentation is required as per University Policy and is for your protection as well as the protection of patients and staff. Please be advised that **you will not** be able to use your UMDNJ student health insurance to cover these requirements as your insurance will not be activated until you are matriculated.

The documentation must be completed within the following timeframe and is a requirement for matriculation:

Now:

- Read through all forms in this packet
- Schedule an appointment with your healthcare provider for a complete history and physical and completion of immunization forms
- Review the "Student Immunization & Health Requirements Policy"
http://www.umdj.edu/oppmweb/university_policies/student_affairs/PDF/00-01-25-40_00.pdf
- Review the Meningococcal Vaccine document enclosed
- Complete and Return Meningococcal Meningitis Response Form
- If you are planning on applying for on-campus residence, you will need to have received a meningococcal vaccination

Due 2 months before start:

- Completed history and physical examination forms (may **not** be dated earlier than February 15, 2009)
- Documentation of all required immunizations on the enclosed form (no other forms will be accepted)
- Copies of any required lab reports (titers, chest-x-ray if necessary)
- The "Hepatitis B Record" (*If you have not had the Hepatitis B immunization series (and the subsequent blood titer to confirm immunity), it may take substantial time to complete. **Please begin immediately***)

Due 1 month before start:

- A "two step" PPD. *This consists of two PPD tests placed approx. 1-3 weeks apart. Each test must be read 48-72 hours after placement.* You may submit documentation of PPD (in millimeters of induration) and additional Hep B vaccines on your healthcare provider's letterhead or prescription pad. **All other immunizations and lab work must be documented on our forms.**

Please make sure to have your health care provider complete, sign and date all forms. Bring the attached **checklist** to your provider so that the appropriate tests are performed. This may help to avoid unnecessary costs to you, as any incurred costs related to the above requirements are your responsibility.

If you have any questions or require additional information please contact the Student Health and Wellness Center at: **(973) 972-7687**.

Please mail or FAX the completed forms to:

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

Sincerely,

Robin Schroeder, MD
Medical Director

*****URGENT! These requirements can take substantial time to complete, so please obtain immunizations and required tests right away.**

The enclosed forms must be completed by you and your health care provider and returned to the Student Health and Wellness Center eight weeks prior to the beginning of the semester you enroll. Please contact us if you have any questions or concerns. Our office number is 973-972-7687.

Health Care Provider: Immunization Check List

- A completed history and physical, **that must be dated, signed and stamped by the student's primary care provider, on our forms.**

- Tdap (tetanus/diphtheria/acellular pertussis) (Adacel) students must receive one dose of Tdap if two or more years have passed since the last Td booster dose or since the primary DPT series

- 2 doses of the Measles vaccine, or a Rubeola IgG titer showing positive immunity results
If using LabCorp the test # is 096560 Quest Diagnostic test # is 52449W

- 1 dose of the Mumps vaccine, or a Mumps IgG titer showing positive immunity results
If using LabCorp the test # is 096552 Quest Diagnostic test # is 64766R

- 1 dose of the Rubella vaccine, or a Rubella IgG titer showing positive immunity results
(It is okay to have 2 doses of MMR to satisfy the above)
If using LabCorp the test # is 006197 Quest Diagnostic test # is 83626F

- 2-step PPD * regardless of history of having received BCG
 - Please include date placed and date read with mm (millimeters) of induration
 - For a positive PPD, you must submit the date and size of induration, along with a current (within the past 12 months) chest x-ray report

- 3 doses of Hepatitis B vaccine are required. If all 3 doses have previously been received, you must have a QUANTITATIVE Hepatitis B Surface Antibody titer showing immunity.
If using LabCorp the test # is 006395 Quest Diagnostic test # is 51938W

- Hepatitis B Core Antibody and Hepatitis B Surface Antigen titers are **required**. This is to determine past or current infectivity.
If using LabCorp for HepBcAB Total test # is 006718 Quest Diagnostic test # is 51870E
If using LabCorp for HepBsAG test # is 006510 Quest Diagnostic test # is 265F

- 2 doses of the Varicella vaccine or a Varicella IgG titer showing positive immunity results
If using LabCorp the test # is 096206 Quest Diagnostic test # is 54031E

* From MMWR: Guidelines for Preventing The Transmission of *Mycobacterium Tuberculosis* in Health-Cater Settings, 2005. Two-step testing is recommended for healthcare workers (HCWs) whose initial Tuberculin Skin Test (TST)(PPD) results are negative. If the first-step TST result is negative, the second-step TST should be administered 1- 3 weeks after the first TST result was read. If either 1) the baseline first-step TST result is positive or 2) the first-step TST result is negative but the second-step TST result is positive, TB disease should be excluded, and if it is excluded, then the HCW should be evaluated for treatment of latent TB infection (LTBI). If the first and second-step TST results are both negative, the person is classified as not infected with *M. tuberculosis*. If the second test result of a two-step TST is not read within 48 – 72 hours, administer a TST as soon as possible (even if several months have elapsed) and ensure that the result is read within 48 -72 hours.



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™) One dose required	____/____/____ mm dd yy		

Healthcare provider information:

Print Name _____

Address _____

Phone _____

Signature _____

Date _____

Return form to:
 Ms. Celia Abalos, JD
 UMDNJ/Office on Housing
 65 Bergen Street, Ste 1441
 Newark, NJ 07101
 973-972-5048 (Fax)

University of Medicine and Dentistry of New Jersey

Meningococcal Meningitis Response Form

Student Name: _____

Student Date of Birth: _____

UMDNJ School: GSBS NJDS NJMS SN SHRP

SPH SOM RWJMS OTHER

Campus: Camden Newark Piscataway/New Brunswick

Scotch Plains Stratford Other: _____

Meningitis Information

I have received information about the nature of meningococcal meningitis disease, disease prevention and treatment, and the availability of a meningococcal vaccine to prevent disease.

Yes() No()

Meningococcal Vaccine

Check one below:

() I have already received the meningococcal vaccine (___ / ___ / ___)
Date

() I have decided not to receive the meningococcal vaccine.

() I plan to receive the meningococcal vaccine in the future.

() I am undecided about receiving the meningococcal vaccine.

Student signature: _____ Date: _____

* This form shall become part of the student health record and is required by New Jersey law, P.L. 2000c.25.

MENINGOCOCCAL VACCINES

WHAT YOU NEED TO KNOW

Many Vaccine Information Statements are available in Spanish and other languages. See 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 fluid surrounding the brain and spinal cord.

Meningococcal disease also causes blood infections.

About 1,000 - 2,600 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 survive, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become 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 with certain medical conditions, such as lack of a spleen. College freshmen who live in dormitories, and teenagers 15-19 have an increased risk of getting meningococcal disease.

Meningococcal infections can be treated with drugs such as penicillin. Still, about 1 out of every ten people who get the disease dies 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)** was licensed in 2005. It is the preferred vaccine for people 2 through 55 years of age.
- **Meningococcal polysaccharide vaccine (MPSV4)** has been available since the 1970s. It may be used if MCV4 is not available, and 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. Meningococcal vaccines cannot prevent all types of the disease. But they do protect many people who might become sick if they didn't get the vaccine.

Both vaccines work well, and protect about 90% of people who get them. MCV4 is expected to give better, longer-lasting protection.

MCV4 should also be better at preventing the disease from spreading from person to person.

3 Who should get meningococcal vaccine and when?

A dose of MCV4 is recommended for children and adolescents 11 through 18 years of age.

This dose is normally given during the routine pre-adolescent immunization visit (at 11-12 years). But those who did not get the vaccine during this visit should get it at the earliest opportunity.

Meningococcal vaccine is also recommended for other people at increased risk for meningococcal disease:

- College freshmen living in dormitories.
- Microbiologists 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 terminal complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

MCV4 is the preferred vaccine for people 2 through 55 years of age in these risk groups. MPSV4 can be used if MCV4 is not available and for adults over 55.

How Many Doses?

People 2 years of age and older should get 1 dose. Sometimes a second dose is recommended for people who remain at high risk. Ask your provider.

MPSV4 may be recommended for children 3 months to 2 years of age under special circumstances. These children should get 2 doses, 3 months apart.

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 either meningococcal vaccine should not get another dose.
- Anyone who has a severe (life threatening) **allergy to any vaccine component** should not get the vaccine. Tell your provider 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 provider. People with a **mild illness** can usually get the vaccine.
- Anyone who has ever had **Guillain-Barré Syndrome** should talk with their provider before getting MCV4.
- Meningococcal vaccines may be given to pregnant women. However, MCV4 is a new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed.
- 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.

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 fever.

Severe problems

- Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.
- A serious nervous system disorder called **Guillain-Barré Syndrome** (or GBS) has been reported among some people who received MCV4. This happens so rarely that it is currently not possible to tell if the vaccine might be a factor. Even if it is, the risk is very small.

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever, weakness, or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

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 doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.
Or you can file this report through the VAERS web site 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

A federal program exists to help pay for the care of anyone who has had a rare serious reaction to a vaccine.

For information about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at www.hrsa.gov/vaccinecompensation.

8 How can I learn more?

- Ask your doctor or nurse. They 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)**
 - Visit CDC's National Immunization Program website at www.cdc.gov/vaccines
 - Visit CDC's meningococcal disease website at www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm
 - Visit CDC's Travelers' Health website at wwwn.cdc.gov/travel



IMMUNIZATION RECORD

Name _____
Last Name First Name

Address _____
Street City State Zip

Start Date ____/____/____ Grad. Year ____/____/____ Date of Birth ____/____/____ Social Security # _____ - _____ - _____
Mo Yr Mo Yr Mo Dy Yr

School -- Please Check One: NJMS _____ NJDS _____ GSBS _____ SPH _____ SN _____ SHRP _____ VISITING _____
Program Program Rotation

Health Service
Use Only

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (all items must be completed).

A. ADULT Tdap (TETANUS, DIPHTHERIA & ACCELLULAR PERTUSSIS) (Adacel)

1. Tdap if two or more years have passed since the last Td booster..... ____/____/____ A
M D Y

B. MMR (Measles, Mumps, Rubella)

1. Dose 1 given at 12 months after birth or later and Dose 2 after 1980 1. ____/____/____ 2. ____/____/____ B
M D Y M D Y

OR INDIVIDUAL MMR AS SPECIFIED IN C, D and E:

C. MEASLES (Rubeola) (2 Doses of Live Vaccine Required)

1. Dose 1 of live vaccine at 12 months after birth or later and Dose 2 after 1980 1. ____/____/____ 2. ____/____/____ C
OR M D Y M D Y
2. Serologic immunity. Specify date (attach lab results) ____/____/____
M D Y

D. RUBELLA (German Measles)

1. Live vaccine at 12 months after birth or later ____/____/____ D
OR M D Y
2. Serologic immunity. Specify date (attach lab results) ____/____/____
M D Y

E. MUMPS

1. Live vaccine at 12 months after birth or later ____/____/____ E
OR M D Y
2. Serologic immunity. Specify date (attach lab results) ____/____/____
M D Y

F. TUBERCULOSIS (PPD required regardless of prior BCG)

1. PPD (2 STEP) Result #1: _____ mm induration (horizontal diameter). Date read ____/____/____ F
M D Y
If Result #1 < 10mm, PPD#2 must be done 1-3 weeks later. Result #2: _____ mm induration (horizontal diameter). ____/____/____
M D Y
2. All PPD's >10mm Date: _____ mm induration: _____ Was INH taken?: Yes ___ No ___ How long? _____
3. If 10mm, or greater, chest x-ray required within the past 12 months (attach report). X-ray result: Normal ___ Abnormal ___ Date: _____

G. HEPATITIS B

1. Completion of at least two of three required doses prior to the start of school: Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
G
AND M D Y M D Y M D Y
2. Hepatitis B Surface Antibody Titer – Required 1 – 2 months after dose #3 (attach lab results)..... ____/____/____
(titer must be QUANTITATIVE not qualitative) M D Y

H. VARICELLA (Chicken Pox)

1. Immunized (Varivax - 2 doses required) 1. ____/____/____ 2. ____/____/____ H
OR M D Y M D Y
2. Serologic immunity. Specify date (attach lab results) ____/____/____
M D Y

Need	Ok

HEALTH CARE PROVIDER (must be completed)

Print Name _____ Address _____

Signature _____

Date _____ Phone (____) _____

Fax (____) _____

UMDNJ/Student Health & Wellness Center
90 Bergen Street
DOC Suite 1750
Newark, NJ 07103-2499
Phone: (973) 972-7687
Fax: (973) 972-0018

Student 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 SS#: ____-____-____ 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: _____
(Last) (First) (MI)

School/Year/Program: _____
(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 in the past year? * Yes No

*SHWC requires a gynecology exam (and Pap smear if indicated) within the past 12 months to obtain low-cost contraception at the Student Health & Wellness Center. We strongly encourage you to bring a copy of your most recent gynecology exam and Pap smear for your Student Health records.

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

Signature _____

Date _____

Contents of Student Health & Wellness Center 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 the Student Health & Wellness Center 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 physician, nurse practitioner, or physician's assistant who is not a relative)

Physical Exam: (date of exam must be within 6 months of matriculation 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: _____

Date of Exam: ____/____/____

Clinician Signature: _____

Clinician Name – Printed: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Office Telephone: _____ Office Fax: _____

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

HEPATITIS B RECORD

Name _____
Last Name First Name

Address _____
Street City State Zip

Date of Entry ____/____/____ Date of Birth ____/____/____ Social Security Number ____-____-____
Mo Yr Mo D Yr

School -- Please Check One: NJMS _____ NJDS _____ GSBS _____ SPH _____ VISITING _____
SHRP _____ SN _____
Program Program

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (all items are MANDATORY).

- 1. Hepatitis B surface antibody (anti-HBs) Neg/Pos ____/____/____ 1
 (titer must be **QUANTITATIVE** *not* qualitative) M D Y
 (attach report)
- 2. Hepatitis B core antibody (anti-HBc) Neg/Pos ____/____/____ 2
 (attach report) M D Y
- 3. Hepatitis B surface antigen (HBsAg) Neg/Pos ____/____/____ 3
 (attach report) M D Y
 If positive, must include #3a
- 3a. Hepatitis Be antigen (HBeAg) (include if #3 is positive) Neg/Pos..... ____/____/____ 3a
 (attach report) M D Y

Health Service Use Only	
Need	Ok

For the complete UMDNJ "Student Immunizations & Health Requirements" go to
http://www.umdnj.edu/oppmweb/university_policies/student_affairs/PDF/00-01-25-40_00.pdf

HEALTH CARE PROVIDER (must be completed):

Print Name _____ Address _____
 Signature _____
 Date _____ Phone (____) _____
 Fax (____) _____
