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.umdnj.edu/oppmweb/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
- Obtain a **"two step" PPD** 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.

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**
- 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.

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 Services
90 Bergen Street
Doctor's Office Center, Suite 1750
Newark, NJ 07103-2499
FAX: 973-972-0018

Sincerely,

Robin Schroeder, MD
Medical Director

Health Care Provider Check List

☐ A completed health history and physical exam, **dated, signed and stamped by the healthcare provider, on our forms.**

☐ Adult Tdap (tetanus/diphtheria/acellular pertussis) (Adacel) (one-time administration)

☐ 2 doses of Measles vaccine, or a Rubeola IgG titer showing immunity- **attach lab report**

LabCorp test # 096560 Quest Diagnostic test # 52449W

☐ 1 dose of Mumps vaccine, or a Mumps IgG titer showing immunity**- attach lab report**

LabCorp test # 096552 Quest Diagnostic test # 64766R

☐ 1 dose of Rubella vaccine, or a Rubella IgG titer showing immunity**- attach lab report**

LabCorp test # 006197 Quest Diagnostic test # 83626F

☐ 2 doses of MMR satisfies above requirement for measles, mumps and rubella

☐ 2-step PPD * regardless of history of having received BCG

- Please include date read with mm. (millimeters) of **induration**
- For a PPD ≥10 mm now or in the past, you must submit the date and size of induration, and a chest x-ray report within the past 12 months

OR

- FDA approved blood assay for TB (Quanteferon Gold)

☐ 3 doses of Hepatitis B vaccine are required. If all 3 doses have previously been received, please provide a **QUANTITATIVE** Hepatitis B Surface Antibody titer (the result must be a number) **attach lab report**

LabCorp test # 006395 Quest Diagnostic test # 51938W

☐ Hepatitis B Core Antibody Total and Hepatitis B Surface Antigen titers are **required- attach lab report**
This is a CDC recommendation for all healthcare workers. Your patient will not be permitted to matriculate without these tests.
LabCorp Hep B Core Antibody Total test # 006718 Quest Diagnostic test # 51870E
LabCorp Hep B Surface Antigen test # 006510 Quest Diagnostic test # 265F

☐ 2 doses of Varicella vaccine or a Varicella IgG titer showing immunity**- attach lab report**

LabCorp test # 096206 Quest Diagnostic test # 54031E

***From MMWR: Guidelines for Preventing The Transmission of *Mycobacterium Tuberculosis* in Health-Care 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*.

Revised
01/5/11

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

Name _____ _____
Last Name First Name

Address _____
Street City State Zip

Start Date ____/____ (M Y) Grad. Date ____/____ (M Y) Date of Birth ____/____/____ (M D Y) Cell #: _____

School -- Please Check One: NJMS____ NJDS ____ GSBS ____ SPH _____ SN _____ (Program) SHRP _____ (Program) VISITING_____ (Rotation)

Health Service Use Only

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

	Need	Ok
A. ADULT Tdap (TETANUS, DIPHTHERIA & ACELLULAR PERTUSSIS) Adacel ™……___/___/___ (M D Y) A		
B. MMR (Measles, Mumps, Rubella) 1. Dose 1 given at 12 months after birth or later and Dose 2 after 1980 ..... #1. ____/____/____ (M D Y) #2 ____/____/___ (M D Y) **OR INDIVIDUAL MMR AS SPECIFIED IN C, D and E:** B		
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.___/____/____ (M D Y) #2. ____/____/___ (M D Y) **OR** C		
2. Serologic immunity **(attach lab report & record date of lab test)** ..... ____/____/___ (M D Y)		
D. RUBELLA (German measles) 1. Live vaccine at 12 months after birth or later ..... ____/____/____ (M D Y) **OR** D		
2. Serologic immunity **(attach lab results & record date of lab test)** ..... ____/____/____ (M D Y)		
E. MUMPS 1. Live vaccine at 12 months after birth or later ..... _____/___/____ (M D Y) **OR** E		
2. Serologic immunity **(attach lab results & record date of lab test** ..... ____/____/____ (M D Y)		
F. TUBERCULOSIS - *PPD required **regardless** of prior BCG* **If Result #1 ≥ 10mm, PPD#2 is not required** 1. **PPD (2 STEP)** **Result #1:** _____ mm induration (horizontal diameter). Date read ____/____/____ (M D Y) F . **Result #2:** _____ mm induration (horizontal diameter). Date read ____/____/____ (M D Y)		
2. **For PPD ≥10mm** mm induration: _____ Date read: ___/___/___ (M D Y) Was INH taken? Yes __ No ___ How long? _____		
3. If ≥10mm, chest x-ray required within past 12 months **(attach report)**…… Date: ____/____/____ (M D Y)		
OR		
4. FDA approved blood assay for TB(Quantiferon Gold) **(attach report)**…… Date: _____/_____/_____ (M D Y)		
G. VARICELLA (Chicken Pox) G		
1. (2 doses required) ..... # 1.____/____/___ (M D Y) # 2. ____/____/____ (M D Y) **OR**		
2. Serologic immunity **(attach lab results & record date of lab test)** ..... ____/____/____ (M D Y)		

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**

Health Services Only

H. Hepatitis B
At least two of three doses are required prior to the start of school:

Dose #1 ____/____/____ **Dose #2** ____/____/____ **Dose #3** ____/____/____
M D Y M D Y 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)..... ____/____/____ **I**
M D Y

J and K are required, regardless of vaccination history

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

K. Hepatitis B Surface antigen (attach lab report)..... ____/____/____
M D Y
If K is positive, must include L **K**

L. Hepatitis Be antigen (HBeAg) (attach lab report)..... ____/____/____
M D Y
L required only if K is positive **L**

M. Meningococcal vaccine (required for UMDNJ housing application processing)
____/____/____ **M**
M D Y

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

0. Health History & Physical (attach UMDNJ FORM) ..... ____/____/____
M D Y
O

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.

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**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf

University of Medicine and Dentistry of New Jersey

Meningococcal Meningitis Response Form

Student Name: _____

Student Date of Birth: _____

UMDNJ School: o ❑GSBS o ❑NJDS o❑ NJMS o ❑SN o ❑SHRP _____

o ❑ SPH ❑SOM o❑ RWJMS ❑OTHER _____

Campus: o ❑Camden o ❑Newark o ❑Piscataway/New Brunswick___

o ❑Scotch Plains ❑Stratford o ❑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.

o Yes( ) o No( )

Meningococcal Vaccine

Check one below:

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

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

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

o( ) 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.

UMDNJ
University of Medicine & Dentistry of New Jersey

Meningococcal Vaccine Form

Student Name: _____ Date of Birth:_____
(Last) (First)

UMDNJ School: o GSBS o NJDS o NJMS o SHRP o SN o SPH oOTHER

MENGINGOCOCCAL 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	
Meningococcal vaccination	Date given	review #1	review #2
(MCV4) tetravalent conjugate (Menactra™ or Menveo™) Memonune acceptable if given 2005 or ealier	___/___/___ mm dd yy		

Healthcare provider information:

Print Name _____

Address _____

_____

Phone _____

Signature _____

Date _____

Return form to:

UMDNJ/Office on Housing
65 Bergen Street, Ste 1441
Newark, NJ 07101
973-972-5048 (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 ❑½ - 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: _____	**High Cholesterol**	❑Yes	❑No	Who: _____
Heart Disease	❑Yes	❑No	Who: _____	**Stroke**	❑Yes	❑No	Who: _____
Diabetes	❑Yes	❑No	Who: _____	**Alcoholism**	❑Yes	❑No	Who: _____
Cancer	❑Yes	❑No	Who: _____	**Type:** _____			
Psychiatric	❑Yes	❑No	Who: _____	**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	❑	❑	❑	_____
Skin (scars, tatoos)	❑	❑	❑	_____
Head	❑	❑	❑	_____
Eyes	❑	❑	❑	_____
Ears, Nose, Throat	❑	❑	❑	_____
Neck	❑	❑	❑	_____
Lymph Nodes	❑	❑	❑	_____
Breasts	❑	❑	❑	_____
Heart	❑	❑	❑	_____
Lungs	❑	❑	❑	_____
Abdomen	❑	❑	❑	_____
Pelvic Exam	❑	❑	❑	_____
GU Exam	❑	❑	❑	_____
Spine	❑	❑	❑	_____
Extremities	❑	❑	❑	_____
Neurological Exam	❑	❑	❑	_____

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

_____

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

Print Name: _____ _____

Signature _____ **Phone:** _____

Date _____ **Fax:** _____