THE LEADER IN GLOBAL EDUCATION
FAIRLEIGH DICKINSON UNIVERSITY

Commuter Student Immunization Record

Rev. 2 (2013-07-10)

NOT CONFIDENTIAL
Immunization records are not confidential as required by law

Name: ______________________________________ Male ☐ Female ☐
Last *First* *Middle*

Student ID: ____________________ Date of Birth: __ m m d d y y y y __

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR
If convenient, you may attach an official copy of your immunization records, which must include all previous and recent shots

1. REQUIRED IMMUNIZATIONS (Laboratory Report must be submitted for any blood titers)

MMR #1 ____________ #2 ____________ **OR** **Titers**

Note: Measles has to be live, after 1st Birthday

Measles	#1 ________	#2 ________	Date ________	Immune ☐	Non-immune ☐
Mumps	#1 ________	#2 ________	Date ________	Immune ☐	Non-immune ☐
Rubella	#1 ________	#2 ________	Date ________	Immune ☐	Non-immune ☐

Hepatitis B #1 ____________ **OR** **Titers**
#2 ____________ #3 ____________ Date ____________ Immune ☐ Non-immune ☐

2. TUBERCULOSIS TEST (Must be within the 6 months prior to the start date of student's first semester)

Mantoux/PPD Test
Date Given __________ Date Read __________ **Result:** Negative☐ Positive☐ Size________mm *(induration)*

OR

QuantiFERON-TB Gold or T-spot Test
Date______________ Result______________________ (*MUST ATTACH LAB REPORT*)

If TB Test is Positive, please complete the <u>Positive TB Test Checklist</u> (Chest X-ray Required)

3. MENINGOCOCCAL MENINGITIS

MENINGOCOCCAL MENINGITIS INFORMATION IS AVAILABLE AT:
http://www.cdc.gov/meningitis and also at www.fdu.edu/shsmetro

Having read the above information, please check one of the following options:

☐ I received the meningitis vaccine on: _______-_______-__________
MM DD YYYY

☐ I **<u>DO NOT</u>** wish to receive the vaccine.

Student Signature: ______________________________ Date:________________

Signature of Medical Provider: ______________________ Date: ____________

Medical Provider: ________________________ Phone: (   ) __________

Address: ____

License Number
OR
Official Stamp of Medical Provider

Remember! Proof of Immunity is required prior to registration.
You will be put on medical hold unless you meet all entrance requirements

THE LEADER IN GLOBAL EDUCATION
FAIRLEIGH DICKINSON UNIVERSITY

Physical Examination

Rev. 2 (2013-07-10)

CONFIDENTIAL - TO BE COMPLETED BY A HEALTH CARE PROVIDER

Name: ____ Male ☐ Female ☐
Last *First* *Middle*

Student ID: ______________________ Date of Birth: __m m__d d__y y y y__

MEDICAL INFORMATION

Blood Pressure ____________ **Height** ____________ **Weight** ____________ **Pulse** ____________

SYSTEMS REVIEW (If abnormal was checked, please comment)

System	Normal	Abnormal	Comments
Eyes			[Vision: Glasses / Contacts]
Head, Ears, Nose, Throat			
Respiratory			
Cardiovascular			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Gynecological			

ALLERGIES / MEDICAL & PSYCH. CONDITIONS / RECOMMENDATIONS

Allergic reactions to medications: (Please list)	
Food, insect or environmental allergies: (List all)	
Medical condition(s) requiring ongoing care: (Include letter from M.D.)	
Psychiatric conditions(s) requiring ongoing care: (Include letter from M.D.)	

Physical Activity (PE, intramurals): Unlimited ☐ Limited ☐ [Explain: ________________________________]

Do you have any recommendations regarding the care of this student? Yes ☐ No ☐
[If Yes, Explain: ____]

Does this student have special needs that require accommodations including but not limited to academics, housing, dietary, or transportation? Yes ☐ No ☐ [If Yes, please include supporting documentation]

Student Nurses: Any use of non-prescribed or illegal substances which may impair their ability to perform safely as a Student Nurse?
Yes ☐ No ☐

Medications

Diagnosis	Medication	Dosage	Prescribing Physician

Psychotropic Medications

Diagnosis	Medication	Dosage	Prescribing Physician

Signature of Medical Provider: ____________________________ Date: ______________

Medical Provider: ______________________________ Phone: (   ) __________

Address: ____

License Number OR Official Stamp of Medical Provider

THE LEADER IN GLOBAL EDUCATION
FAIRLEIGH DICKINSON UNIVERSITY

Student Profile

CONFIDENTIAL
Information used solely to provide necessary health care

Rev. 2 (2013-07-10)

STUDENT PROFILE (To be completed by the student in ink)

Name: ____ Male ☐ Female ☐
Last First Middle

Student ID: ____________________ Date of Birth: ___m m d d y y y y___

Date entering FDU: ___m m y y y y___ Citizenship: ______________________

Admission Status: Undergraduate ☐ Graduate ☐ International ☐ Transfer ☐ Nursing ☐ Athlete ☐

Mailing Address: ____
Street Address City State Zip Code

Home Phone: ( ) __________ Cell Phone: ( ) __________ E-Mail: ______________

Father's/ Legal Guardian's Name: ________________________ Phone: ( ) __________

Mother's/ Legal Guardian's Name: ________________________ Phone: ( ) __________

Where do you plan to live? Resident ☐ Commuter ☐ (If are a commuter, provide the address where you will reside)

Address: ____ Phone: ( ) __________
Street Address City State Zip Code

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: ________________________________ Relationship: ______________

Address: ____
Street Address City State Zip Code

Home Phone: ( ) __________ Work Phone: ( ) __________ Cell Phone: ( ) __________

HEALTH/HOSPITALIZATION INSURANCE

Insurance Company Name: ____________________Policy # __________ Group # ________

Address: ____ Phone: ( ) __________
Street Address City State Zip Code

Is the student the insured? Yes☐ No☐ [If No, Name of Insured: ______________ Relationship: __________]

FDU Student Insurance? Yes ☐ No☐ FDU Student Insurance is **required** for all International Students.

All full-time undergraduate and graduate students enrolling in the Fall and Spring semester who wish to waive University coverage must provide evidence of comparable health medical expense coverage. Insurance premium is included in the college fees each semester. Proof of comparable coverage is required by the Higher Education Restructuring Act of 1994. *****Insurance waiver cards are available in Enrollment Services and must be submitted to Enrollment Services.*****

Permission for medical care:
I authorize Fairleigh Dickinson University Student Health Services to provide medical services and when circumstances require immediate action, to notify the emergency contact. Yes ☐ No ☐

Permission for use of e-mail address:
I authorize Fairleigh Dickinson University Student Health Services to use my e-mail address. Yes ☐ No ☐

Student Signature: ____ Date: ____________

If student is under 18 years of age:
Parent/Guardian Signature: ____________________ Relationship: __________ Date: ____________

Records are due: July 15th for Fall, December 1st for Spring, April 15th for Summer

THE LEADER IN GLOBAL EDUCATION
FAIRLEIGH DICKINSON UNIVERSITY

Medical History

CONFIDENTIAL

To be completed by the student.

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Name: ____ Male ☐ Female ☐

Last *First* *Middle*

Student ID: ______________________ Date of Birth: ___m m _ d d _ y y y y___

FAMILY HISTORY (Check all that apply.) (Please use COMMENTS section if additional details are needed for clarification.)

Condition	Mother	Father	Sibling	Condition	Mother	Father	Sibling
Alcohol/Drug abuse	☐	☐	☐	High Blood Pressure	☐	☐	☐
Asthma	☐	☐	☐	Kidney Disease	☐	☐	☐
Cancer	☐	☐	☐	Mental/Emotional Illness	☐	☐	☐
Deceased (age)	☐	☐	☐	Stroke	☐	☐	☐
Heart Disease	☐	☐	☐	Tuberculosis	☐	☐	☐

PERSONAL HEALTH HISTORY (Check YES or NO.) (Please use COMMENTS section if additional details are needed.)

	YES	NO		YES	NO		YES	NO
Abusive/controlling relationship			Gallbladder trouble			Operations or serious injury (list details below)		
Alcohol/drug abuse			Head injury			Pneumonia		
Anemia			Heart disease/problems			Paralysis		
Arthritis			Hepatitis/jaundice			Psychological problems		
Asthma			High blood pressure			Rheumatic fever		
Bronchitis			HIV/AIDS			Self-harming behavior		
Cancer			Hospitalization (list details below)			Sexually transmitted disease		
Chicken Pox, if yes then date: _______________			Intestinal/stomach trouble			Sickle cell trait/anemia		
Convulsions/seizures			Kidney disease/bladder problems			Sinus trouble		
Diabetes			Lyme disease			Skin disorder		
Disability (Physical or Learning)			Menstrual problems			Sleep difficulties		
Ear trouble/hearing loss			Migraine headaches			Smoking/tobacco use		
Eating disorder			Mononucleosis			Thyroid disease		
Eye disease/vision problems			Muscle, joint/bone disorder			Tuberculosis		

Are there other aspects of your health that might cause problems for you or require special accommodations (including academics, housing, dietary, and transportation) at FDU? If so, please specify._________________________________

MEDICATIONS TAKEN REGULARLY (Include ALL prescription medications.)

_________________________________ _________________________________

Medication/Dosage/Frequency *Medication/Dosage/Frequency*

DRUG ALLERGIES *(Please specify.)*

____

ALLERGIES (Please specify; include food, insect, and environmental allergies.)

____

COMMENTS (If needed, please continue COMMENTS section on the back of this page.)

____

I _______________________________ declare that all of the above information is true to the best of my knowledge.

Print Name

Student Signature: ____ Date: ________________

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Meningitis Response

IMPORTANT INFORMATION

Rev. 2 (2013-07-10)

Name: ____ Male ☐ Female ☐
Last First Middle
Student ID: ______________________ Date of Birth: m m d d y y y y

MENINGITIS VACCINATION INFORMATION

Meningococcal meningitis is a contagious, potentially life threatening bacterial infection that causes inflammation of the membranes that surround the brain and spinal cord. Permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure, or death can result from the infection. Although the disease is rare, the outbreaks of meningitis on college campuses have risen in the recent years. While the reasons are not yet fully understood, students residing in campus residence halls appear to be at a higher risk for the disease than college students overall.

Vaccination is an effective way for students to protect themselves against possible infection. The vaccine provides protection against four strains of Meningococcal disease, which together account for nearly 70% of Meningococcal cases on campus. The vaccine is safe with mild and infrequent side effects. Immunity develops within seven to ten days, and remains effective for approximately five years. In the past, vaccination usually has been delayed until an outbreak of meningitis occurs. However, because outbreaks are clustered in time, and because onset of symptoms is extremely rapid, it makes sense for students to consider reducing their risk with a vaccination before an outbreak occurs.

IMPORTANT INFORMATION FOR RESIDENTS

New Jersey Administrative Code 8:57-6 requires all new students who reside in campus housing to receive a meningococcal vaccination. Students who do not plan to live on campus are encouraged to consider the vaccination on a voluntary basis. Students who have received the vaccine during the five years previous to the start date of their first semester do not need to be revaccinated. Since this vaccination is mandated by law for new resident students, housing will be revoked if the vaccine is not obtained prior to move-in day.

VACCINE AVAILABILITY

The meningitis vaccine is available at Fairleigh Dickinson University Student Health Services.

RESPONSE (If you have received the vaccine, provide verification of the same)

Having read the above information, please check one of the following:

☐ I am a Resident Student and have received the vaccine on m m d d y y y y ______________________.

☐ I have already received the meningitis vaccine within the past five years on m m d d y y y y ______________________.

☐ I do <u>not</u> wish (my student) to receive the vaccine (Commuters Only)

☐ I have decided to receive the meningitis vaccine at some future time (Commuters Only)

Student Signature: ______________________________________ Date: ______________

If student is under 18 years of age:
Parent/Guardian Signature: ____________________ Relationship: ____________ Date: ______________

Students in University Housing require the Meningitis Vaccine