



**FAIRLEIGH  
DICKINSON  
UNIVERSITY**

Student Health Services  
Metropolitan Campus

**STUDENT HEALTH SERVICES**  
**Metropolitan Campus**  
1000 River Road, T-SU2-03  
Teaneck, New Jersey 07666  
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Dear Student,

The Student Health Services staff welcomes you to the University, and we offer our support in any way possible during your study at Fairleigh Dickinson University.

As all institutions of Higher Education have an obligation to ensure the public health of its students, we collect and review medical and immunization records for all matriculated FDU students. Your health care provider will need to complete the *Immunization Record* and *Physical Exam* forms included in the attached packet. The student is responsible to complete the *Student Profile, Medical History* and *Meningitis Response* forms.

**DEPENDING ON WHAT TYPE OF STUDENT YOU ARE (RESIDENT, COMMUTER, NURSING, OFF-SITE), THERE ARE DIFFERENT REQUIREMENTS. PLEASE COMPLETE AND SUBMIT THE APPROPRIATE FORMS.**

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**OFF-SITE STUDENTS:** Students who are taking classes at an off-site location only need to submit the *Off-Site Student Immunization Record*. **If you are taking classes on the Metropolitan or Florham Campus you are NOT an Off-Site student.** You must submit the COMMUTER packet of forms.

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Please understand that you will not be permitted to register for class until the health forms and immunization records are completed and received.

**Required Medical Entrance Forms due:**

- **Fall Semester: July 15th**
- **Spring Semester: December 15th**
- **Summer Semester: March 15th**

Medical records are an entrance requirement for all incoming students. Required entrance forms are available on our website: [www.fdu.edu/shsmetro](http://www.fdu.edu/shsmetro). Please **MAIL** your completed forms to the address listed on the top of this page.

**Medical records are strictly confidential and are not part of the academic records. Medical records are used exclusively by Student Health Services Metro to provide personalized care. Any information on these records or concerning a visit to Student Health Services Metro will not be released without written permission from the individual treated. Immunization records are an exception and are not confidential since your immunization status must be made available to New Jersey State Inspectors and select University offices in order to comply with New Jersey State Law. We strongly recommend that you keep a copy of your immunization records.**





# Medical History

CONFIDENTIAL

Rev. 6 (2014-09-09)

To be completed by the student.

Name: \_\_\_\_\_ Male  Female   
Last First Middle  
 Student ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental/Emotional Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased (age)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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
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**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: \_\_\_\_\_





# Meningitis Response

Rev. 2017-5-17

## IMPORTANT INFORMATION *(Please Read)*

Name: _____			Male ___	Female ___
Last	First	Middle		
Student ID: _____		Date of Birth _____		

### MENINGITIS VACCINATION INFORMATION

Meningococcal disease can be devastating and often-and unexpectedly-strikes otherwise healthy people. Although meningococcal disease is uncommon, teens and young adults 16 through 23 years old (not just those in college) are at increased risk. Meningococcal bacteria can cause severe disease, including infections of the lining of the brain and spinal cord (meningitis) and bloodstream infections (bacteremia or septicemia), and can result in permanent disabilities and even death. Common symptoms are: confusion, fatigue (feeling very tired), rash of dark purple spots, sensitivity to light, stiff neck, vomiting, headache, high fever, nausea.

Anyone can get meningococcal disease, but certain groups are at increased risk. These include:

- College students and military recruits living in dorms or barracks
- People with certain medical conditions or immune system disorders including a damaged or removed spleen
- People who may have been exposed to meningococcal disease during an outbreak
- International travelers

Meningococcal bacteria are spread person-to-person through the exchange of saliva or nasal secretions. The bacteria are not spread by casual contact or by breathing the air where a person with meningococcal disease has been. One must be in direct (close) contact with an infected person's secretions in order to be exposed. Close contact includes activities such as: living in the same household, kissing, sharing eating utensils, food, drinks, cigarettes, etc.

The best way to prevent meningococcal disease is to get vaccinated. There are two kinds of vaccines in the United States that protect against 4 types of meningococcal disease known as A/C/Y/W-135. Two doses are recommended for all adolescents. The first dose is recommended at 11-12 years of age. Since protection wanes, a booster dose is recommended at age 16 years so adolescents continue to have protection during the ages when they are at highest risk of meningococcal disease.

Meningococcal vaccines are safe and effective. As with all vaccines, there can be minor reactions, including pain and redness at the injection site or a mild fever for one or two days. Severe side effects, such as a serious allergic reaction, are very rare. It is important to know that 1) no vaccine offers 100% protection, 2) protective immunity declines 3-5 years after the first dose of meningococcal vaccine and a booster dose is needed to provide continued protection; 3) Meningococcal Meningitis A/C/Y/W-135 vaccine contains only 4 of the 5 most common types of meningococcal disease and; 4) not all cases of meningitis are caused by meningococcal bacteria. Symptoms of meningitis in a vaccinated person should always warrant immediate medical attention regardless of vaccination.

#### Where can I get more information about meningococcal vaccine?

Your Healthcare Provider, and  
Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/meningococcal/index.html>

#### RESPONSE (If you have received the vaccine, provide verification of the same on proof of immunizations – not on this form)

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

- \_\_\_ I am a Resident Student and have received the vaccine on \_\_\_\_\_
- \_\_\_ I have already received the meningitis vaccine within the past five (5) years on \_\_\_\_\_
- \_\_\_ I do not wish (my student) to receive the vaccine (Commuters Only).
- \_\_\_ I have decided to receive the meningitis vaccine at some future time (Commuter Only).

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If student is under 18 years of age, sign and date:*

Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Meningitis Vaccine is Mandatory for Students in University Housing**



# Immunization Record

Not Confidential

Immunization records are not confidential  
as required by law

Name: \_\_\_\_\_ Male \_\_\_ Female \_\_\_  
Last First  
 Student ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER. GIVE MONTH, DAY & YEAR

If convenient, you may attach a signed/stamped 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 Titters: \_\_\_\_\_  
 \*Note: Measles has to be live after 1<sup>st</sup> birthday  
 Measles #1 \_\_\_\_\_ #2 \_\_\_\_\_ | Date \_\_\_\_\_ Immune\_\_ Non-Immune\_\_  
 Mumps #1 \_\_\_\_\_ #2 \_\_\_\_\_ | Date \_\_\_\_\_ Immune\_\_ Non-Immune\_\_  
 Rubella #1 \_\_\_\_\_ #2 \_\_\_\_\_ | Date \_\_\_\_\_ Immune\_\_ Non-Immune\_\_

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Varicella (Chicken Pox) Disease \_\_\_\_\_ | OR Titters: \_\_\_\_\_  
 Or Vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_ | Date \_\_\_\_\_ Immune\_\_ Non-Immune\_\_

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Hepatitis B Vaccine #1 \_\_\_\_\_ | OR Titters: \_\_\_\_\_  
 #2 \_\_\_\_\_ #3 \_\_\_\_\_ | Date \_\_\_\_\_ Immune\_\_ Non-Immune\_\_

**2. TUBERCULOSIS TEST (Mantoux/PPD within past 6 months, regardless of prior BCG inoculation)**

**Mantoux/PPD Test**  
 #1 Date Given \_\_\_\_\_ Date Read \_\_\_\_\_ Result: Negative\_\_ Positive\_\_ Size \_\_\_\_\_ mm (induration)  
**If Mantoux (PPD) is Positive, Chest X-ray and a discussion of Chemoprophylaxis is required: *Please see/download the Positive TB Test Checklist Form***

**3. Meningococcal Containing Vaccine\*** Date \_\_\_\_\_ (*Required for all Resident Students*)

**\*STUDENTS CANNOT LIVE ON CAMPUS UNLESS THEY PROVIDE PROOF TO STUDENT HEALTH SERVICES THAT THEY RECEIVED A MENINGOCOCCAL MENINGITIS A/C/Y/W-135 VACCINATION WITHIN THE PAST 5 YEARS OF CAMPUS ARRIVAL. MEN B VACCINE IS NOT REQUIRED *BUT* IT IS RECOMMENDED FOR ALL STUDENTS. \*\***

\*\*Teens and young adults (16 through 23 years old) may also be vaccinated with Men B vaccine (serogroup B meningococcal vaccine, brand names are Bexsero & Trumenba). Two or three doses are needed depending on the brand.

**4. Tdap (within the last 10 years)** Date \_\_\_\_\_ (TD Not Acceptable)

Signature of Medical Provider: _____ Date _____	License Number Or Official Stamp of Medical Provider
Name of Medical Provider: _____	
Address: _____ Phone: _____	

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