FAIRLEIGH DICKINSON UNIVERSITY

Student Health Services
Metropolitan Campus

STUDENT HEALTH SERVICES
Metropolitan Campus
1000 River Road, T-SU2-03
Teaneck, New Jersey 07666
Phone: (201) 692-2437
Fax: (201) 692-2642

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.

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.

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**. 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.*

FDU
Student Health Services
Metropolitan Campus

Student Profile

CONFIDENTIAL

Information used solely to provide necessary health care.

Rev. 10 (2016-11-9)

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

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

Student ID: _____ Date of Birth: _____

Date entering FDU: _____ 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: ( ) _____

AUTHORIZATIONS

Permission for medical care:

I authorize Fairleigh Dickinson University Student Health Services to provide medical services. Yes ☐ No ☐

To notify the above listed emergency contact, as deemed appropriate. Yes ☐ No ☐

Permission for use of e-mail address:

To communicate with me through the above listed e-mail address to use my e-mail address. Yes ☐ No ☐
(the University will never communicate health information through e-mail and we strongly recommend that you don't either)

Student Signature: _____ Date: _____

If student is under 18 years of age:

Parent/Guardian Signature: _____ Relationship: _____ Date: _____

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

FDU
Student Health Services
Metropolitan Campus

Medical History

CONFIDENTIAL

To be completed by the student.

Rev. 6 (2014-09-09)

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	☐	☐	☐	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: _____

FDU
Student Health Services
Metropolitan Campus

Physical Examination

CONFIDENTIAL - TO BE COMPLETED BY A HEALTH CARE PROVIDER

Rev. 16 (2014-09-09)

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

Student ID: _____ Date of Birth: _____

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

FDU
Student Health Services
Metropolitan Campus

Meningitis Response

IMPORTANT INFORMATION

Rev. 7 (2014-09-09)

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

Student ID: _____ Date of Birth: _____

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 _____.

☐ I have already received the meningitis vaccine within the past five 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 (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

FDU
Student Health Services
Metropolitan Campus

Resident Student Immunization Record

Rev. 4 (2014-09-09)

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/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 ☐

Varicella (Chicken Pox) Disease _____ | **OR** **Titers**

OR Vaccine #1 _____ #2 _____ | Date _____ Immune ☐ Non-immune ☐

Hepatitis B #1 _____ | **OR** **Titers**

#2 _____ #3 _____ | Date _____ Immune ☐ Non-immune ☐

Meningococcal Containing Vaccine: Date _____ ***(Required for ALL Resident Students)***

Adult Tdap: Date _____

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 Positive TB Test Checklist (Chest X-ray Required)

Signature of Medical Provider: _____ Date: _____

Medical Provider: _____ Phone: ( ) _____

Address: _____

License Number OR Official Stamp of Medical Provider

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