Felician UNIVERSITY
THE FRANCISCAN UNIVERSITY OF NEW JERSEY

Center for Health

ENROLLMENT PREREQUISITE HEALTH FORM

This Form must be received by the Center for Health prior to beginning classes and/or moving into the Residence Halls. It is mandatory that all students complete this health form, attach all relevant documentation as directed, and return it to the

Center for Health wellness@felician.edu
One Felician Way, Rutherford, NJ 07070
Telephone 201-559-3559. Fax 201-559-3579

It is **YOUR** responsibility to make sure the health forms and requirements were received by the Center for Health.

Please read carefully and complete as instructed. PLEASE PRINT:

Part I. General Information

Major_____ Entry Date_____

Last Name _____ First Name_____ Last 4 digits of SSN#_____

If you are under the age of 18, Parental Consent must be signed by a Parent or a Guardian. Date Of Birth _____/_____/_____

Marital Status: Single_____ Married_____ Maiden Name_____ Male_____ Female_____

Address_____City_____State_____ZIP_____

Phone_____Alternate Phone_____ E-Mail Address_____

Emergency Contact: Name_____Phone_____Alternate Phone_____

Address_____City_____State_____ZIP_____

Relationship of Emergency Contact to student_____ Are you a citizen of the United States? Yes_____ No_____

Do you have Health Insurance coverage? Yes_____ No_____ **If yes, please attach a copy of your insurance card**.

Will you be residing on the Felician University Campus? Yes____ No____

Have you attended Felician University before? Yes_____ No_____
If yes, what semester did you last attend class? _____
Under what name did you last attend class? _____

Part II. History

Personal History: List any previous hospitalizations, surgeries, major injuries, and chronic illnesses with dates (mo/yr).

List all current **medications.** Include amount and dosage per day:_____

List **allergies** (medications, environmental, food, other)_____

Family History: If any blood relative has suffered any of the following, please circle the number & indicate which relative.

1. Epilepsy	5. Alcoholism	9. Tuberculosis
2. Mental Illness	6. Cancer	10. Asthma
3. Diabetes	7. High Blood Pressure	11. Kidney Disease
4. Heart Disease	8. Stroke	12. Hayfever/Hives

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Part III. Physical Examination

Required for all students. Must have occurred during the 12 months prior to admission. Other documentation of a physical exam by a Licensed Health Care Provider during the 12 months prior is acceptable in lieu of this form.

Student's Name: (PLEASE PRINT) **Date:**

Height: Weight: BMI: BP: Pulse:

Vision: Hearing:

System	**Findings: (must be completed by Provider)**	
	WITHIN NORMAL LIMITS	ABNORMAL
1. General Survey/Psychological		
2. Integument		
3. Eyes		
4. Ears		
5. Nose/Sinuses		
6. Mouth/Pharynx		
7. Neck/Thyroid		
8. Thorax/Lungs		
9. Breasts		
10. Heart/PV		
11. Abdomen		
12. Hernia		
13. MS/Motor Function/Extremities		
14. Spine		
15. Neurological		
16. Lab; U/A		

Can the student participate in all academic activities? Yes__ No__

Explain: _____

Can the student participate in all physical activities? Yes__ No__

Explain: _____

Is the student currently under treatment for any medical condition? Yes__ No__

Explain: _____

Can the student participate in any clinical/laboratory activities? Yes___ No___ N/A___

Explain: _____

Do you have any general comments or recommendations? _____

List immunizations and/or titers done at time of visit. (record mantoux tests with results on page 3) _____

Licensed Health Care Provider's Signature **Date**

Printed Name (Provider's Stamp preferred) **Phone**

Address (Office Stamp preferred)

Print Name _____ **Last 4 of SSN** _____

Part IV. TUBERCULOSIS: MANTOUX (PPD) Tuberculin Skin Test

A 2 Step Mantoux (PPD) is required for **ALL Nursing Students the form can be found on Felician University Website. Mantoux (PPD) MUST be done no sooner tha** 7 days and no longer than 30 days to be considered a **valid test**.

Required for all students. **Must have been administered during the 6 months prior to admission.**

The following information is to be completed by your Licensed Health Care Provider. To be a valid test, the date placed, date read, and size of the reading in millimeters must be documented. (A negative reading would be 0mm.)

The test is invalid without signature of Provider, and if read less than 48 hours or more than 72 hours after being placed.

Lot #: _____ **Exp.Date:** _____ **MFR:** _____

Date Placed: _____ **Date Read:** _____ **Results:** _____ **mm**

Licensed Health Care Provider Signature _____ **Date** _____

Printed Name (Provider's Stamp preferred) _____ **Phone** _____

Address (Office Stamp Preferred) _____

In the event of any current or previous positive results (horizontal diameter > 10mm induration), ALL of the following must be submitted.

1. Copy of positive results documentation.
2. Copy of chest x-ray report. (actual x-ray film not required)
3. Documentation of INH prophylaxis treatment including dates of the treatment.
4. Completed Symptom Assessment For Tuberculosis Form. (available at the Center for Health or online at http://felician.edu/campus-life/student-resources/student-wellness/student-health-requirements)

Part V. Meningococcal (Meningitis) Mandatory University Survey

Required for all students.

This Survey is to be completed by ALL students.

Ensure one box in section 1 and one box in section 2 are checked and it is signed and dated.

NOTE: All students residing on campus MUST have received the Meningitis Vaccine PRIOR to moving into residential housing.

Meningococcal (Meningitis) Mandatory University Survey*

**This survey becomes part of the student's health record and is required by New Jersey State law, P.L. 2000c25.*

Meningococcal Disease is a serious, potentially fatal bacterial illness. Anyone can get Meningococcal Disease but University students, especially those who live in dormitories and teenagers 15-19, have an increased risk of getting Meningococcal Disease. Accordingly, all university students in the State of New Jersey are to be provided information about Meningococcal Disease and available Vaccinations so that in collaboration with their Health Care Provider they may make an informed decision about receiving the Vaccine.

(check one box in this section) **Survey Section 1: Meningitis Information**

I have been informed about Meningococcal Disease. I have been informed there is a vaccine available for this disease, and informed of the effectiveness of this vaccine against this disease.

I am aware that I can contact the Center for Health at Felician University or my Health Care Provider if I have any questions.

I understand that to be protected against Meningococcal Disease I must receive the vaccine, and until I do I remain at risk for contracting this disease.

I am in receipt of the Meningococcal Vaccines Information Statement (VIS) that provides information about Meningococcal Disease and vaccines.

☐ Yes ☐ No

(check one box in this section) **Survey Section 2: Meningitis Vaccination**

- ☐ I have already received the Meningitis Vaccine.
- ☐ I have decided to receive the Meningitis Vaccine now or at some future time.
- ☐ I have decided not to receive the Meningitis Vaccine.
- ☐ I am undecided about whether or not to receive the Meningitis Vaccine.

Student Signature: _____ Date: _____

Print Name _____ **Last 4 of SSN** _____

Part VI. Immunizations and/or Titers

Note a 2 Step PPD is required for ALL nursing students. Form can be found on website.

Attach Proper Documentation for items A thru D to prove immunization or immunity as Required by New Jersey State Law.

This includes: official school immunization records, public health department records, and/or official records signed by a Licensed Health Care Provider. This page 4 may be submitted in lieu of other documents if completed and signed by a Licensed Health Care Provider.
Exact dates are required.

Immunizations: **Required** for all students. **Blood Titers:** **Required** for all **Nursing** students.

Note: Lab evidence of Blood Titer results showing immunity are acceptable in lieu of documentation of Immunization.

Exemptions allowed by the NJ Department of Health to Immunizations:

1. Medical reasons (must provide written documentation from Primary Care Provider).
2. Religious reasons (must provide written documentation stating objection).

(Those with medical/religious exemptions may be temporarily excluded from class/activities during threatened or actual disease outbreaks.)

A. MMR (MEASLES, MUMPS, RUBELLA) :

ALL students born after 1956 **must** provide **one** of the following:

Measles (Rubeola) - 2 doses of live vaccine (1st dose on or after 1st birthday and 2nd dose after 1980) ***OR*** a positive **Rubeola IgG Titer**.
Mumps - 1 dose of live vaccine on or after 1st birthday ***OR*** a positive **Mumps IgG Titer**.
Rubella (German Measles) - 1 dose of live vaccine on or after 1st birthday ***OR*** a positive **Rubella IgG Titer**.

(NURSING students are Required to provide positive Rubeola IgG Titer, Mumps IgG Titer and Rubella IgG Titer results regardless of age.)

B. VARICELLA (Chickenpox)*:*

ALL students **must** provide **one** of the following **regardless of age**:

1. Documentation of 2 doses of Varivax®, 4-8 weeks apart.
2. Written statement by Licensed Health Care Provider of having had the disease and what year it occurred.
3. Copies of lab evidence of a positive Varicella Zoster IgG Titer.

(NURSING students are Required to provide positive Varicella Zoster IgG Titer results.)

C. HEPATITIS B SERIES:

ALL students **must** provide **one** of the following **regardless of age**:

1. Documentation of 3 doses Hepatitis B Vaccine over a six month period (0, 1, 6 mos.).
2. Copies of lab evidence of a positive Hepatitis B Surface Antibody Titer.

(NURSING students are Required to provide positive Hepatitis B Surface Antibody Titer - Quantitative, Hepatitis B Surface Antigen, Hepatitis B Total Core and Hepatitis C Virus Antibody)

For students who have not completed all 3 doses of Hepatitis B vaccine, **Provisional Periods** (Temporary Clearances) have been established to do so.
If not completed by the end of the Provisional Period a Health Hold will be placed on the student's record which will preclude them from continuing.

9 months - no vaccine previously received
6 months - 1 documented dose of vaccine received
4 months - 2 documented doses of vaccine received

D. TDAP: **ALL** nursing students **must** provide documentation of tetanus, diptheria and pertussis vaccine.

D. MENINGOCOCCAL MENINGITIS VACCINE : REQUIRED for students residing on campus.

If Meningitis vaccine is greater than 5 years ago, a booster is required (NJ Law). If the 1st dose given after the 16th birthday, a booster is not needed.
New Jersey State Law **requires** that all students living in residence halls at four year institutions of higher education receive the vaccine.
This vaccine is **recommended** for all other students under age 25 and living off campus who want to reduce their risk of meningitis.

IMMUNIZATIONS

MMR	1	2	
Measles			
Mumps			
Rubella			
Varicella Vaccine		1	2
Varicella Disease (Date)			
Hepatitis B	1	2	3
Meningococcal		1	2
Polio	1	2	3
Tdap	1	2	
Influenza	1		

SEROLOGY (Required for Nursing students.)

Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:
Varicella	Date:	Titer:
Hepatitis B Ab Qu	Date:	Titer:

Copies of actual lab results must be submitted with this form.

In accordance with New Jersey Department of Health and Senior Services, **equivocal results are treated as negative results and boosters will be required.**

Licensed Health Care Provider's Signature _____ **Date** _____

Provider's Stamp _____ **Phone** _____

Address (Office Stamp preferred) _____