Dear Incoming Student,

Congratulations on your acceptance to Caldwell University and a warm welcome to the Caldwell University Community.

All full-time students are required to complete and return the original health form to the Health Services Department by the due date. *Please note that there are additional requirements for students residing in campus housing which can be found on the health form. Failure to complete this form in its entirety will result in registration and/or campus housing holds. **Forms cannot be faxed or emailed.**

Acceptable proof of immunizations:
- Immunization page of the Caldwell University Health Form completed and signed by your licensed health care professional
- Official school immunization records
- Public Health Department record

If you unable to obtain proof of past immunization, you must be either revaccinated or provide a laboratory report showing immunity. Immunization and testing for immunity are available through your personal health care provider.

Limited exemptions are allowed for religious and medical reasons. Requests for exemptions must be submitted in detailed writing. Medical exemptions must be signed by your health care provider. Students submitting religious or medical exemptions must provide this office with documentation of any previously administered immunizations. It is important to know that in the case of an outbreak of a communicable disease on campus, students who have submitted exemptions will not be allowed to remain on campus or attend classes until it is deemed safe by the Department of Health.

Please note that health information provided to this office is confidential, and will not be released without written permission or pursuant to government regulation. Immunization records are not confidential because your immunization status must be made available to state inspectors and select University officials in order to comply with New Jersey law.

If you have any further questions regarding your health form, please contact Health Services at 973.618.3319.

We wish you health, happiness, and success as you pursue your academic goals.

Health Services Staff
PHYSICAL EXAMINATION FORM

Please check:

☐ Adult Undergraduate
☐ Graduate

Adult Student
Residing in
Campus Housing

DUE DATE:
Fall Semester Entry July 15th
Spring Semester Entry Dec. 15th

Please read carefully and complete ALL sections. Return form to Health Services at above address by due date. Incomplete forms will be returned to applicant and will jeopardize admittance to class and the residence halls.

STUDENT SECTION

PLEASE PRINT

Name: ___________________________ ___________________________ ___________________________

Last First Middle

Birth Date: _____/_____/_______ M ( ) F ( ) Age: _________ Student ID# (if known): ____________________________

Month Day Year

Home Address: ____________________________________________________________

City: ___________________________ State: __________ Zip Code: ___________________________ Country: __________

Home Phone: (______)_________________________ Cell Phone (______)_______________________

In case of an emergency or emergency transport to a hospital, please contact:

Primary Contact: (next of kin)

Name ___________________________________________________________ Relationship ______________________________

Address ___________________________________________________________________________________________________

Daytime Phone: (_____) __________________________ Evening Phone: (_____) __________________________ Cell Phone: (_____)

Secondary Contact:

Name ___________________________________________________________ Relationship ______________________________

Address ___________________________________________________________________________________________________

Daytime Phone: (_____) __________________________ Evening Phone: (_____) __________________________ Cell Phone: (_____)

CONSENT/AUTHORIZATION:

My signature below indicates that: I consent to medical treatment by the Caldwell University Health Services Staff. I authorize Caldwell University, its employees, agents, or representatives, to take whatever action it/they consider to be warranted regarding my health and safety, and I release Caldwell University for any and all liability for such action. If I require services, prescriptions, or referrals beyond the primary care services available at Caldwell University Health Services, I shall assume full financial responsibility for those services. I consent to the administration of emergency medical treatment, and understand I am financially responsible for any treatment received from off-campus healthcare providers on my behalf in emergency situations. I authorize Caldwell University, its employees, agents, or representatives to contact the individual listed as my Emergency Contact in case of an emergency or in the event that Caldwell University determines such contact is in my best interest.

_______________________________________________

Signature of Student ___________________________

Date
### MEDICAL HISTORY (to be completed by student)

#### EYE
- Corrective Lenses/Contacts: No  Yes
- Other Visual Problems: No  Yes

#### URINARY
- Kidney Stones: No  Yes
- Urinary Tract Infection: No  Yes

#### ENT (Ear, Nose, and Throat)
- Hearing Impairment: No  Yes
- Recurrent Throat Infections: No  Yes

#### MUSCULOSKELETAL
- Back Problems: No  Yes
- Disease or Injury of Joints: No  Yes

#### CARDIOVASCULAR
- High Blood Pressure: No  Yes
- Palpitations: No  Yes
- Heart Murmur: No  Yes
- Fainting: No  Yes

#### HEMATOLOGICAL/ONCOLOGICAL
- Anemia: No  Yes
- Cancer: No  Yes
- Sickle Cell Disease: No  Yes
- Abnormal Bleeding/Bruising: No  Yes

#### RESPIRATORY
- Shortness of Breath: No  Yes
- Asthma: No  Yes
- Bronchitis: No  Yes
- Tobacco Use: No  Yes

#### GASTROINTESTINAL
- Irritable Bowel Syndrome: No  Yes
- Surgeries: No  Yes
- Constipation: No  Yes
- Diarrhea: No  Yes

#### NEUROLOGICAL
- Head Injury/Concussion: No  Yes
- Date of injury/concussion: ______________________
- Seizures: No  Yes
- Headaches: No  Yes
- Fainting: No  Yes
- Dizziness: No  Yes

#### REPRODUCTIVE SYSTEM
- Women:
  - Irregular Periods: No  Yes
  - Severe Cramps: No  Yes
  - History of Sexually Transmitted Disease: No  Yes
- Men:
  - Swelling of Scrotum/Testicles: No  Yes
  - History of Sexually Transmitted Disease: No  Yes

#### ENDOCRINE
- Diabetes: No  Yes
- Thyroid: No  Yes

#### HEALTH AND NUTRITION
- Do you follow a special diet? No  Yes
- Do you have an eating disorder? No  Yes

#### MENTAL HEALTH
- Depression: No  Yes
- Anxiety: No  Yes
- Previous psychological counseling: No  Yes
- Current psychological counseling: No  Yes
- History of Suicide Ideation: No  Yes
- History of Suicide Attempts: No  Yes
- Psychotropic medications and dose (please list):
  - 
  - 
  - 
  - 
  - 

#### DRUG AND ALCOHOL USAGE
- Have you ever felt you should cut down on your drinking? No  Yes
- Have people annoyed you by criticizing your drinking? No  Yes
- Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover? No  Yes
- Have you ever used any of the following substances (please circle all that apply): marijuana, prescription medications for recreational use, ecstasy, molly, bath salts, heroin, cocaine, OTHER)

#### FAMILY HISTORY
- Circle all that apply
  - High Blood Pressure:  
  - Heart Disease:  
  - Cancer:  
  - Diabetes:  
  - Thyroid Disease:  
  - High Blood Pressure:  
  - Heart Disease:  
  - Cancer:  
  - Diabetes:  
  - Thyroid Disease:  

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**Name:**

**Last**

**First**
Caldwell University Health Services

PHYSICAL (Must have been performed by a physician within 12 months of the start of the student’s first semester)  All Sections Must be Fully Completed.

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<thead>
<tr>
<th>BP / P / R</th>
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<td>Eyes</td>
<td>WNL</td>
<td>Remarks:</td>
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<tr>
<td>Ears</td>
<td>WNL</td>
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<td>Nose</td>
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<td>Throat</td>
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<td>Remarks:</td>
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<td>Neck</td>
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<td>Remarks:</td>
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<td>Lungs</td>
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<td>Remarks:</td>
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<td>Heart</td>
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<td>Abdomen</td>
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<td>Lymph glands</td>
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<td>G.U.</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Musculoskeletal</td>
<td>WNL</td>
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Please list ALL current medications: ________________________________________________________________

_______________________________________________________________________________________________

Allergies: ______________________________________________________________________________________

_______________________________________________________________________________________________

Does student have any physical/mental disability which should limit participation.. YES / NO (Check those that apply)

□ Campus Residency  □ Classroom Activities  □ Competitive Sports

If yes, please explain: _____________________________________________________________________________

_______________________________________________________________________________________________

Has student received treatment or counseling for a psychiatric condition, personality disorder or emotional problem? YES / NO

If yes, please explain: _____________________________________________________________________________

_______________________________________________________________________________________________

Physician’s Name (please print) _________________________________________________________________

Address _______________________________________________________________________________________

Phone# _________________________________________ Fax#___________________________________________

Physician’s Signature ___________________________ Date of completed exam ___________________ 

Office stamp (required):
**IMMUNIZATION RECORD**
(Immunization records are NOT confidential)

Name: ____________________________________________________________________________________

Last                                                                       First
Middle

Birth Date: ________/______/_______
Month                            Day                   Year

Your health care provider must complete this page, provide any supporting documentation and SIGN below, OR you may attach acceptable evidence of vaccination to the form. ALL information must be in English.

**REQUIRED VACCINATIONS:**

**Measles, Mumps, Rubella: New Jersey State Law requires that all students provide documentation of two Measles, one Mumps and one Rubella vaccination given on or after your first birthday and separated by at least 28 days OR copy of laboratory test results proving immunity.**

<table>
<thead>
<tr>
<th>OR</th>
<th>MMR #1</th>
<th>MMR #2</th>
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<tbody>
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<td>Month  /  Day / Year</td>
<td>Month / Day / Year</td>
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**Measles:**
Date: #1 ________/______/______  Date: #2 ________/______/______
Month          Day          Year                                          Month          Day          Year

**Mumps:**
Date: ________/______/______
Month          Day          Year

**Rubella:**
Date: ________/______/______
Month          Day          Year

**Hepatitis B: New Jersey State Law requires that ALL students taking 12 or more credits provide documentation of Hepatitis B vaccine OR copy of laboratory test proving immunity.**

**Hepatitis B Doses:**

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**Meningitis:**
Students will NOT be permitted entry to campus housing without proof of Meningitis vaccination. Vaccination must include Groups A, C, Y, W-135. **Vaccine must have been administered after age of 16 and within five (5) years of entering campus housing.**

- MCV4 (i.e. Menactra, Menveo, Mencevax) Date: 
  Month / Day / Year

**Tuberculosis Screening:** Required for ALL students ENTERING CAMPUS HOUSING. Testing can be either an IGRA or a PPD. ALL international students, commuters and residents, must have an **IGRA Lab test (TB skin testing will not be accepted for international students.)** TB testing must have been performed within 12 months prior to entering housing or the start of the semester for commuters. If an IGRA is performed, a copy of the lab report must be attached to this form. If TB testing is positive, a chest x-ray is mandatory and a copy of the x-ray report must be attached.

- PPD Date Given: ________/______/______  PPD Date Read: ________/______/______  (must be read 48-72 hrs after test)  PPD Results: __________mm
- IGRA Test performed: ___________________________  Date of Lab test: ___________________________  Attach lab report

**STRONGLY RECOMMENDED VACCINATIONS:**

**Diphtheria-Tetanus within the last 10 years:** Date: ________/______/______  or Tetanus, Diphtheria, Pertussis (Tdap): Date: ________/______/______
Month          Day          Year                                          Month          Day          Year

**Varicella (Chickenpox):**

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Health Care Provider's name, address, and signature required by law. WILL NOT BE ACCEPTED WITHOUT SIGNATURE.

Name & title: ______________________________________________ Address: ______________________________________________
(Please print)                                                    (Please print)

Signature: ______________________________________________      Date: ______________________________________________

Phone: ____________________________

Office Stamp (required):
Dear Student:

The Health Services Department would like to inform you about a serious health hazard facing college students. This is the growing threat of meningitis on college campuses across the country.

Meningitis is a rare but potentially fatal disease with early symptoms that resemble the flu, making diagnosis difficult. The symptoms include high fever, severe headache, stiff neck, confusion, nausea and vomiting, exhaustion and/or a rash. If not treated early, meningitis can lead to severe and permanent disabilities, even death.

Meningococcal bacteria are transmitted through air droplets and by direct contact with infected persons. It occurs most often in late winter and early spring—when most college students are away at school. Cases of meningitis among teens and young adults 15-24 years of age—the age of most college students—have more than doubled since 1991. It is estimated that between 100-125 meningitis cases occur on college campuses each year and as many as 15 students will die from the disease.

While the reason for this rise in college campus outbreaks is not fully understood, studies suggest that college students are more susceptible because they live and work in close proximity to each other in dormitories and classrooms. Life style appears to be a risk factor as well, with exposure to active and passive smoking, alcohol consumption, and bar patronage all increasing the chances of contracting meningitis from an infected individual.

A vaccine is available that protects against four of the five strains of the bacteria that causes meningitis in the United States. These types account for nearly two-thirds of meningitis cases among college students. New Jersey State Law requires any student planning to live in campus housing must have a meningitis vaccine prior to moving into housing. In addition, the American College Health Association (ACHA) recommends that all other college students consider vaccination against meningitis to protect them against this serious disease.

In support of this recommendation, you are encouraged to discuss meningitis with your physician and consider vaccination prior to your college entrance. It is important to note that if you will be residing in campus housing, you must submit proof of a meningitis vaccine according to the guidelines on the immunization page of the health form.

Sincerely,
Cynthia Striano, M.S.N., R.N.
Executive Director of Health Services
Meningitis Survey

Please complete the survey below and return to Health Services in the enclosed envelope along with your completed health records:

Please note:
STUDENTS RESIDING IN CAMPUS HOUSING must complete #1, all other students must choose between statements 1-4.

I acknowledge that I have received and read the information about meningitis and the meningitis vaccine.

Please check one:

1. I have received the meningitis vaccine on _________.
   (date)

2. I have decided to receive the meningitis vaccine at a later date. ________

3. I have decided not to receive the meningitis vaccine. ________

4. I am undecided about whether or not to receive the meningitis vaccine. _____

Student’s Name: ________________________ Date_________________
(Please print)

Signature: _____________________________________________________