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 upload it to:

Medicat Health Portal **Portal can be found on our website:** Email: wellness@felician.edu

Center for Health - Felician University of New Jersey

It is **YOUR** responsibility to make sure the health forms and requirements are 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 & reactIons** (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. Hay Fever

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 Care Provider during the 12 months prior is acceptable in lieu of this form.

Student's Name: (Please Print) _____ Date: _____

Height: _____ Weight: _____ BMI: _____ BP: _____ Pluse: _____

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/Sinus		
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 test with results on page 3) _____

_____

Licensed Health Care Provider Signature _____ Date _____

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

Address (Office Stamp preferred) _____

Felician UNIVERSITY
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Print Name: Last 4 of SSN:

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

Mantoux (PPD) MUST be done no sooner than7 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:_____
Licensed Health Care Provider Signature_____Date: _____
Printed Name (Providers 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 Wellness Services)

Part V. Meningococcal (Meningitis) Mandatory University Survey

Required for all students

This Survey is to be completed by ALL students

Ensure one box is 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 become part of the student's health record and is required by New Jersey State Law, PL 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)

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)

Section 2: Meningitis Vaccination

☐ I have already received the Meningitis Vaccine.

☐ I am undecided about whether to receive 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.

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,

For students who have not completed all 3 doses of Hepatitis B vaccine, **Provisional Periods** (Temporary Clearances) have been established to do so.

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. (after the age 18)

E. MENINGOCOCCAL MENINGITIS (MCV4) 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 MCV4			
Tdap	1	2	
Meningitis B	1	2	3

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)

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NURSING 2024-2025

Student: _____ Date: _____

Thank you for the submission of your Student Health Documents.
FAILURE TO SUBMIT THIS REQUIRED INFORMATION MAY RESULT IN THE WITHOLDING OF FUTURE REGISTRATION AND FINAL GRADES.

All information should be uploaded to Medicat Healthcare Portal under *My Felician Hub.* Please feel free to contact us with any questions you may have regarding your Student Health Record at **(201) 559-3559.**

- ☐ Enrollment Prerequisite Health Form (pages 1-4). Felician Health Forms can be downloaded via Adobe Acrobat from the college website: https://felician.edu/campus-life/center-for-health/
- ☐ Completed Meningococcal (Meningitis) Mandatory College Survey (page 3 of health form). Ensure one box checked in section 1 and section 2 as well signature and dated on the bottom of the page.
- ☐ Physical Exam during the past 12 months.
- ☐ Documentation **2 Step PPD Required** (Tuberculin skin test) ***or*** negative **QuantiFERON-TB Gold** and TB Symptoms Assessment Form (available from the Center for Health or online) ***or*** documentation of positive PPD (in mm) ***with*** copy of chest x-ray report ***and*** any treatment taken or declined.
- ☐ Documentation of #1Measles immunization (given after 1st birthday) ***and*** documentation of #2 Measles immunization after 1980 ***or*** documented immunity through a blood test for **Rubeola Antibody Titer IgG** (titer **required** for Nursing students).
- ☐ Documentation of Mumps immunization (after 1st birthday) ***or*** documented immunity through a blood test for **Mumps Antibody Titer IgG** (titer **required** for Nursing students).
- ☐ Documentation of Rubella immunization (after 1st birthday) ***or*** documented immunity through a blood test for **Rubella Antibody Titer IgG** (titer **required** for Nursing students).
- ☐ Documentation of Varicella (chicken pox) immunizations (2 doses) ***or*** documented immunity by ***either*** a statement from your Licensed Health Care provider of having had the disease ***or*** a blood test for **Varicella Zoster Antibody Titer IgG** (titer **required** for Nursing students).
- ☐ Documentation of Hepatitis B series (3 doses) ***or*** documented immunity through blood test for **Hepatitis B Surface Antibody Titer (**titer **required** for Nursing students).
- ☐ Tetanus/Diphtheria/Pertussis (TdaP) Booster (one dose after the age of 18)
- ☐ COVID 19 VACCINE and BOOSTER ***REQUIRED FOR ALL STUDENTS***

ANNUAL REQUIREMENTS

- ☐ Annual Physical Exam
- ☐ Annual PPD (after completing 2 Step) or QuantiFERON-TB Gold
- ☐ TB Symptoms Assessment Form* every 6 months
- ☐ 11 Panel LabCorp Chain of Custody Drug Screen (Form must be obtained from Center for Health in person or by mailing request)
- ☐ Influenza Vaccine due by 10/15/23, Fall semester (should be done between October 1st and October 15th) **NOT BEFORE**

Proper documentation is REQUIRED for proof of all immunizations. This includes official school immunization records, records from any public health department, and/or official records signed by a health care practitioner licensed to practice medicine in the U.S. **Exact dates are required.**

****It is advised you keep a personal copy of all medical records you submit****

Colleen A. Mulligan-Moran, BSN-RN
CAWS: Wellness Services
One Felician Way, Rutherford, NJ 07070 (P) 201-559-3559 (F) 201-559-3579
Email: wellness@felician.edu

FELICIAN UNIVERSITY

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Fax: 201-559-3579
Email: wellness@felician.edu

2 Step Tuberculin Skin Test
(TST/PPD/Mantoux)

_____

Print Name **Please read carefully and complete the following.**

I hereby request the Center for Health to administer a 2 Step Tuberculin Skin Test.
I understand that the usual positive reactions include redness, swelling, and/or itching at the site.
I understand that a strongly positive reaction may result in the development of vesicles at the site, ulceration and/or necrosis.
I understand that unless I return to have the test read in **48 to 72 hours**, it is not valid and will need to be redone. I understand any test redone will require the same payment as the initial test.

I am pregnant.	Y	N	I have had:		
			BCG Vaccine	Y	N
I am on corticosteroids.	Y	N	Tuberculosis	Y	N
			A positive TB skin test	Y	N
I am immunocompromised.	Y	N	Any live virus vaccines in the last 6 weeks (Such as Chicken Pox or MMR)	Y	N
I have chronic renal failure	Y	N			

Step One: Signature _____ Date _____

Step Two: Signature _____ Date _____

. . . . . .

Step One

Date Test Placed _____ PPD Placed _____TU Forearm: R L

Lot # _____ Exp. Date _____ MFR _____

Signature _____

Date of Reading _____ Results _____mm

Signature _____

1. Place on volar forearm.
2. Inject intradermal (wheal).
3. Read induration 48-72 hours after test placed. **(Must be read by Nurse/Physician)**
4. Record results as size of induration in millimeters. (e.g. no/negative induration = 0mm)

Step Two (to be completed no less than 7 days and no longer than 30 days after Step One)

Date Test Placed _____ PPD Placed _____TU Forearm: R L

Lot # _____ Exp. Date _____ MFR _____

Signature _____

Date of Reading _____ Results _____mm

Signature _____

1. Place on volar forearm.
2. Inject intradermal (wheal).
3. Read induration 48-72 hours after test placed. **(Must be read by Nurse/Physician)**
4. Record results as size of induration in millimeters. (e.g. no/negative induration = 0mm)