TCNJ Pre-Entrance Health Requirements Packet – Please Print and Read Carefully!

HEALTH REQUIREMENTS ARE COMPLETED IN OWL at https://tcnj.medicatconnect.com/ .

You will not be able to log into OWL until your deposit has been posted and the Office of Admissions has processed your matriculation. Once this process is complete you will be assigned a TCNJ email account, and 24 hours later, you should be able to log into OWL. If you are still encountering problems 2 weeks after depositing, please email Student Health Services at health@tcnj.edu for assistance. NOTE: A physical examination is not required to attend TCNJ.

RECORDS THAT ARE FAXED, EMAILED, MAILED OR BROUGHT IN-PERSON TO OUR OFFICE WILL NOT BE REVIEWED.

1. **New Student Medical History Form** (located in OWL) – Do this FIRST!

   ☐ This form is completed by the student. It is located in OWL (see link above) under "FORMS". It is the first form listed. (If you are a re-admitted/re-entering student and have already completed the New Student Medical History previously, choose the Re-admitted Student Medical History instead).

   ☐ IMPORTANT: One of the last questions on the New Student Medical History form is about Meningococcal Meningitis. Please refer to the attached "Meningococcal Disease and Vaccination Info Sheet" in the packet before answering the question. Note that Meningococcal Meningitis A/,C/,Y/,W-135 vaccination (brand names are Menactra, Menveo, & Menomune) is required for application to TCNJ housing with at least one (1) dose received within the past 5 years before arrival on campus. Men B vaccination (brand names Trumenba & Bexero) is not currently required but it is recommended. Please discuss receiving this vaccine with your healthcare provider.

2. **Record of Immunization form** (pages 1-2 of this packet)

   ☐ Take this form to your healthcare provider to be completed, signed, and office-stamped. All required vaccination fields must be complete.

   ☐ Receive any vaccinations that you are missing. If your doctor does not have the vaccine(s) that you need, a search on your computer will locate an urgent care facility, walk-in clinic or large pharmacy near you that administers these vaccines. They are readily available in the community and in TCNJ Student Health Services. *Students who are completing vaccination series such as Hepatitis B where spacing between doses is necessary can obtain an extension from our office beyond the due date and into the semester if needed for that vaccination.*

   ☐ When the form is complete, log into OWL. Click on "IMMUNIZATIONS". Using the Record of Immunization form as a guide, enter the dates of each of your vaccinations noted on the form. Then click SUBMIT at the bottom of the page. *Do NOT miss this step!*

   ☐ Scan the Record of Immunization form into your computer & save it to a place where you can easily locate it (e.g., your computer desktop). In OWL, click on "UPLOAD". Following the instructions, upload the Record of Immunization form. Other related forms such as laboratory test reports,if you are submitting them in place of vaccination dates, can also be uploaded here.

Dates of immunization must be entered AND the Record of Immunization form uploaded before the Immunization Compliance Specialist can begin her review. When this review has been completed, an email will be sent to your TCNJ email account informing you of the outcome of this review. Allow 5 business days for review.

Continued on next page

A word about UPLOADING: If you do not have a scanner, scanning apps are available for download from the App Store on your smart phone (e.g., CamScanner - free version). Other options are your local public library (most have scanners for free use with a library membership - also free), and your local Staples store (fee charged). Do NOT fax, email, mail or bring records to our office. They will NOT be reviewed and will further delay the clearing of your holds.

3. **Tuberculosis (TB) Screening Questionnaire** (page 3 of this packet)

   ☐ Answer questions 1-7.
   ☐ Upload page 3 into OWL under Physician's Evaluation for Tuberculosis.

4. **Physician's Evaluation for Tuberculosis** (page 4 of this packet)

   - If you answered YES to one or more questions on the Tuberculosis (TB) Screening Questionnaire (page 3), this form is REQUIRED:
     ☐ Schedule an appointment with your doctor for TB testing and evaluation.
     ☐ Have your doctor complete the Physician's Evaluation for Tuberculosis form.
     ☐ Upload the Physician's Evaluation for Tuberculosis into OWL.

   If you answered NO to ALL questions on the Tuberculosis (TB) Screening Questionnaire, this form is **NOT** required.

5. **If you will be NOT be at least 18 years of age when you arrive on campus:**

   ☐ Your parent or court-appointed legal guardian must complete the "**Authorization to Treat a Minor"** form (page 5).
   ☐ Scan the form into your computer. Log into OWL, click UPLOAD, and follow the instructions.

6. **Medical Insurance & Prescription Card** - RECOMMENDED

   Although not required, it is recommended that you upload a copy of the front of your medical insurance & prescription cards. This information will be kept on file in Student Health Services & is not accessible to any other office INCLUDING THOSE OFFICES WHO OVERSEE THE STUDENT HEALTH INSURANCE PLAN WAIVER PROCESS. This means that by providing insurance information to Student Health Services, you are NOT waiving enrollment in the Student Health Insurance Plan.

   ☐ Scan a copy of the front of your medical insurance & prescription insurance cards into your computer (some are separate cards; some are combined on one card). Then log into OWL, click UPLOAD, and follow the instructions. You can identify a Prescription insurance card by its "RX Group #" and "Bin #" information. This information is needed by pharmacists to process a prescription through your insurance.
   ☐ Please be sure to upload new card information if you change insurance plans while at TCNJ.

EMAILED, FAXED, MAILED,or "BROUGHT IN-PERSON" FORMS WILL NOT BE ACCEPTED!

MENINGOCOCCAL DISEASE AND VACCINATION INFO SHEET

NEW JERSEY STATE LAW REQUIRES THAT COLLEGES PROVIDE INCOMING STUDENTS WITH INFORMATION ABOUT MENINGITIS INFECTION AND VACCINATION.
STUDENTS WILL THEN BE ASKED A QUESTION ON THE NEW STUDENT MEDICAL HISTORY IN OWL.

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 (spit) or nasal secretions. These bacteria are not as contagious as the germs that cause the common cold or flu. 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.

Teens and young adults (16 through 23 year olds) **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.

At TCNJ, 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.

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
- TCNJ Student Health Services
- Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/meningococcal/index.html

Rev 7/21/16

RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY

Must be completed, signed & office stamped by a doctor or nurse; then uploaded by the student into OWL

Student's Name: _____ **Birth date:** _____/_____/_____
Last *First* *M D Y*

REQUIRED FOR ALL UNDERGRADUATE STUDENTS:

MEASLES, MUMPS, RUBELLA (MMR) (students born BEFORE 1957 are exempt from the MMR requirement)

OR →	**2 doses of MMR VACCINE** **Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE:** _____/_____/_____ (M D Y) **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:** _____/_____/_____ (M D Y)	**OR**	**LABORATORY PROOF OF IMMUNITY** (see below)
	2 doses of MEASLES VACCINE **Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE:** _____/_____/_____ (M D Y) **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:** _____/_____/_____ (M D Y)	**OR**	MEASLES Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
	2 doses of MUMPS VACCINE **Dose 1 RECEIVED ≥ 12 MONTHS OF AGE:** _____/_____/_____ (M D Y) **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:** _____/_____/_____ (M D Y)	**OR**	MUMPS Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
	1 dose of RUBELLA VACCINE **Dose 1 RECEIVED ≥ 12 MONTHS OF AGE:** _____/_____/_____ (M D Y)	**OR**	RUBELLA Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.

VARICELLA (Chickenpox)

2 doses of VARICELLA VACCINE **Dose 1 RECEIVED ≥ 12 MO OF AGE:** _____/_____/_____ (M D Y) **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:** _____/_____/_____ (M D Y)	**OR**	**LABORATORY PROOF OF IMMUNITY** Varicella Zoster Virus (VZV) IgG Antibody test. Copy of laboratory report must be attached.	**OR**	**History of Chickenpox Infection** Date: _____/_____/_____ (M D Y) *History of infection alone is not acceptable for students entering the health care field. Must receive 2 doses of Varicella vaccine or provide proof of immunity to Varicella.*

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)

1 dose of TETANUS, DIPHTHERIA, PERTUSSIS VACCINE RECEIVED ≥ 11 YEARS OF AGE: _____/_____/_____ (M D Y)

NOTE: Vaccine MUST include Pertussis to be acceptable. If not, revaccinate with Tdap.

Continued on next page

Student's Name: _____ **Birth date:** _____/_____/_____
Last *First* *M D Y*

REQUIRED FOR STUDENTS TAKING 3 OR MORE COURSE UNITS/SEMESTER (FULL-TIME):

HEPATITIS B (NOTE: If beginning vaccination series, no need to accelerate dosing. Series can be completed at TCNJ)

3 doses of HEPATITIS B VACCINE Dose 1: _____/_____/_____ *M D Y* Dose 2: _____/_____/_____ *M D Y* Dose 3: _____/_____/_____ *M D Y*	**OR**	**3 doses of Combined HEPATITIS A & HEPATITIS B VACCINE** Dose 1: _____/_____/_____ *M D Y* Dose 2: _____/_____/_____ *M D Y* Dose 3: _____/_____/_____ *M D Y*	**OR**	**LABORATORY PROOF OF DISEASE OR IMMUNITY TO HEPATITIS B** Copy of laboratory report must be attached.

REQUIRED FOR STUDENTS APPLYING FOR TCNJ HOUSING:

MENINGOCOCCAL MENINGITIS A/C/Y/W-135

One dose received <u>within 5 years of arrival on campus</u>: **Most recent dose:** _____/_____/_____ *M D Y*

U.S. Brand: ☐ *Menveo (Glaxo)* or *Menactra (Sanofi)* ☐ *Menomune* ☐ *Unknown*

Non-U.S. Brand (specify): _____ NOTE: Trumenba & Bexero are **NOT** ACYW Vaccines

DOCTOR: Give Booster dose if received before age 16 to continue protection during age of highest risk (16-23 years)

Recommended Vaccinations (not required):

HEPATITIS A

Dose 1: _____/_____/_____ *M D Y* Dose 2: _____/_____/_____ *M D Y*	**OR**	**Combined Hepatitis A & Hepatitis B Vaccine** *(Document dates of doses on page in box above)*

HUMAN PAPILLOMAVIRUS (HPV)

Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____ **Which one:** _____
M D Y *M D Y* *M D Y*

MEN B VACCINE (Meningococcal meningitis B)

Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____ **Which one:** ☐ Bexero (Sanofi) ☐ Trumenba (Pfizer)
M D Y *M D Y* *M D Y*

Record of Immunization is NOT VALID unless signed & stamped by a PHYSICIAN, PA, APN or RN

Print Name & Title: _____

Signature: _____

Date: _____ Office Telephone: ( ) _____

Office Stamp (REQUIRED)

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

To be completed and signed by the student. Upload into OWL under Physician's Evaluation for Tuberculosis.

Name: _____ **Birth date:** ____/____/____ **PAWS ID:**_____
Last *First* *M* *D* *Y*

Please answer the following questions:

1) Have you ever had a **positive** TB test?……..... ☐ yes ☐ no

2) Have you ever had **close contact** with persons known or suspected to have active TB disease? ..... ☐ yes ☐ no

3) Were you **born** in one of the countries listed below? If yes, please CIRCLE the country ..... ☐ yes ☐ no

4) Have you had any **frequent** (once per year or more) OR **prolonged visits (30 days or more)** to one or more of the countries listed below? If yes, please CHECK ✔the country/ies below…….. ☐ yes ☐ no

5) Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facility, long-term care facility, homeless shelter)?……..... ☐ yes ☐ no

6) Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ yes ☐ no

7) Have you ever been a member of any of the following groups that may have an increased incidence of latent TB infection or active TB disease: - medically underserved, low-income, or abusing drugs and/or alcohol?..... ☐ yes ☐ no

I verify that the information provided by me on this form is true. _____ **Date**_____
Student's signature *(or parent/legal guardian if student is a minor)*

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China (including Taiwan)
Colombia
Comoros
Congo (Democratic Republic of)
Côte d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Korea (Republic of)
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
St. Vincent & The Grenadines
Sao Tome & Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Trinidad & Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with TB incidence rates of ≥ 20 cases per 100,000 population.

If you answered YES to one or more of the above questions, schedule an office visit with your doctor to complete the "Physician's Evaluation for Tuberculosis" on the next page (page . TAKE THIS FORM WITH YOU TO YOUR APPOINTMENT.

If you answered NO to all of the above questions, you are NOT required to have the Physician's Evaluation for Tuberculosis form completed or have a TB test.

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Only required if the student has answered YES to one or more questions on PAGE 3, Tuberculosis Screening Questionnaire.
To be completed and signed by a MD/DO, PA, or NP and uploaded into OWL . Requires an office visit to your doctor.

PHYSICIAN'S EVALUATION FOR TUBERCULOSIS

Student's Name: _____ **Birth date:** _____/_____/_____
Last *First* *M D Y*

1. Has the student had a TB TEST in the past? ☐ Yes ☐ No ☐ Unknown

2. Has the student had a POSITIVE TB test in the past? ☐ Yes ☐ No

   If YES, what test was positive: ☐ Interferon-Gamma Release Assay (IGRA) ☐ TB skin test – Result in mm:_____

   Date of Positive Test: _____/_____/_____
   M D Y
   Chest X-Ray Date: _____/_____/_____ (Copy of Radiologist's report in ENGLISH must be attached) Result: Normal ☐ Abnormal ☐
   M D Y
   Diagnosis: ACTIVE Tuberculosis ☐ Yes ☐ No LATENT Tuberculosis ☐ Yes ☐ No

   Treatment: _____ Completed successfully on _____/_____/_____
   M D Y

3. **TB SYMPTOM CHECK**

   Does the student have signs or symptoms of active pulmonary tuberculosis disease?

   No ☐ Proceed to #4

   Yes ☐ Check symptoms present & proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest x-ray, and sputum evaluation as indicated.

   - ☐ Cough (especially if lasting 3 weeks or longer) with or without sputum production
   - ☐ Coughing up blood (hemoptysis)
   - ☐ Chest pain
   - ☐ Loss of appetite
   - ☐ Unexplained weight loss
   - ☐ Night sweats
   - ☐ Fever

4. **TB TEST -** If no history of a Positive TB test, perform one of the following tests within 6 months before start of classes:

   - TB Skin Test: _____/_____/_____ TB Skin Test read: _____/_____/_____ Result in mm: _____ Neg ☐ Pos ☐
     M D Y *M D Y*
   - Interferon Gamma Release Assay (IGRA): _____/_____/_____ Neg ☐ Pos ☐ **Copy of laboratory report must be attached.**
     M D Y

5. **CHEST X-RAY** if TB test noted above is POSITIVE. **Copy of Radiologist's report in ENGLISH must be attached.**

   Date: _____/_____/_____ Interpretation: Normal ☐ Abnormal ☐
   M D Y

   Diagnosis: ACTIVE Tuberculosis ☐ Yes ☐ No LATENT Tuberculosis ☐ Yes ☐ No Other: _____

NOT VALID unless signed, dated, and stamped by a MD/DO, PA or NP

Print Name & Title: _____

Signature: _____

Date: _____ Office Telephone: ( ) _____

Office Stamp (REQUIRED)

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Student Health Services

AUTHORIZATION TO TREAT A MINOR

Only required for students who will NOT be at least 18 years of age when they arrive on campus.
Page to be completed by the student's parent or court-appointed legal guardian and uploaded into OWL.

I hereby authorize Student Health Services at The College of New Jersey to provide medical and therapeutic care to my minor son/daughter, including but not limited to, diagnostic examinations such as laboratory testing, tuberculosis screening, and the administration of immunizations, or when circumstances require immediate attention, to proceed according to standard medical practice. My child's 18th birthday is _____.

Student's Name: _____ Birth date: _____/_____/_____ PAWS ID #:_____
Last *First* *M* *D* *Y*

_____ _____ _____ _____
[Print name of parent/legal guardian] [Signature of parent/legal guardian] [Relationship to student] {Date}

Emergency Contact Info:

Cell: ( )_____

Home: ( )_____

Work: ( )_____