TCNJ PRE-ENTRANCE HEALTH REQUIREMENT PACKET
FOR GRADUATE STUDENTS

Please Print and Read Carefully!

HEALTH REQUIREMENTS ARE COMPLETED IN THE TCNJ ONLINE WELLNESS LINK, CALLED “OWL”, at https://tcnj.medicatconnect.com/.

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

PLEASE NOTE: You will not be able to log into the Online Wellness Link, “OWL”, until your deposit has been posted and the Office of Graduate Studies 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.

1. STUDENT MEDICAL HISTORY (LOCATED IN OWL) – Do this FIRST! If you cannot yet log into OWL, skip and come back.

☐ This form is completed online in OWL (see link above) in the “FORMS” section. Choose “New Student Medical History” or “Re-admitted Student Medical History”.

☐ One of the last questions on the 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. This vaccination is not required for students living off-campus. However we are required by NJ State Law to provide EVERY student with information about this disease.

2. RECORD OF IMMUNIZATION (PAGES 4 OF THIS PACKET)

☐ Take this form to your healthcare provider to be completed, signed, and office-stamped. All required vaccination fields must be complete. You do not have to use this form – if you have another record of immunization from your doctor, employer, military or school, you can submit it to us via OWL.

☐ Be sure to obtain any required 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 retail 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 pre-entrance health requirements due date and into the semester if needed for that vaccination.
Enter your immunizations with dates into OWL. Log into OWL. Click on “IMMUNIZATIONS“. Using our Record of Immunization form as a guide, type in the dates of each of your vaccinations noted on the form. Then click SUBMIT at the bottom of the page. If you have had chickenpox (the illness), you can enter the date in this section. You do not have to enter anything if you are submitted laboratory immunity test records and not vaccination records.

Upload your immunization record into OWL. If you have laboratory immunity test records, you can upload them as well. In OWL, click on “UPLOAD”. Follow the instructions on this page.

When this review has been completed, an email will be sent to your TCNJ email account informing you of the outcome of this review. It is important that you monitor your TCNJ email account daily for important notices. Allow 5 business days for review.

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 5 OF THIS PACKET)

☐ Answer questions 1-7.

☐ Upload page 5 into OWL under Physician’s Evaluation for Tuberculosis.

4. PHYSICIAN’S EVALUATION FOR TUBERCULOSIS (PAGE 6 OF THE PACKET)

• If you answered YES to one or more questions on the Tuberculosis (TB) Screening Questionnaire (page 5), this form is REQUIRED:

☐ Schedule an appointment with your health care provider for TB testing and evaluation.

☐ Have your healthcare provider complete the Physician’s Evaluation for Tuberculosis form.

☐ Upload the Physician’s Evaluation for Tuberculosis form into OWL.

• If you answered NO to ALL questions on the Tuberculosis (TB) Screening Questionnaire, this form is NOT required.
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, and 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 to provide protection when meningococcal meningitis incidence peaks (16-21 years of age).

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 reason for vaccination.

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

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Date 1 Requirement</th>
<th>Date 2 Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEASLES, MUMPS, RUBELLA (MMR)</td>
<td>Dose 1 RECEIVED AFTER 1968 &amp; ≥ 12 MONTHS OF AGE: <em><strong><strong>/</strong></strong></em>/______ M   D   Y</td>
<td>Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: <em><strong><strong>/</strong></strong></em>/______ M   D   Y</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>OR</td>
<td>LABORATORY PROOF OF IMMUNITY (see below)</td>
<td>OR</td>
</tr>
<tr>
<td>2 doses of MMR VACCINE</td>
<td>MEASLES Virus IgG Antibody test demonstrating immunity.</td>
<td>MUMPS Virus IgG Antibody test demonstrating immunity.</td>
</tr>
<tr>
<td></td>
<td>Copy of laboratory report must be attached.</td>
<td>Copy of laboratory report must be attached.</td>
</tr>
<tr>
<td>2 doses of MEASLES VACCINE</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>MEASLES Virus IgG Antibody test demonstrating immunity.</td>
<td>MUMPS Virus IgG Antibody test demonstrating immunity.</td>
</tr>
<tr>
<td></td>
<td>Copy of laboratory report must be attached.</td>
<td>Copy of laboratory report must be attached.</td>
</tr>
<tr>
<td>2 doses of MUMPS VACCINE</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>MUMPS Virus IgG Antibody test demonstrating immunity.</td>
<td>RUBELLA Virus IgG Antibody test demonstrating immunity.</td>
</tr>
<tr>
<td></td>
<td>Copy of laboratory report must be attached.</td>
<td>Copy of laboratory report must be attached.</td>
</tr>
<tr>
<td>1 dose of RUBELLA VACCINE</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>RUBELLA Virus IgG Antibody test demonstrating immunity.</td>
<td>RUBELLA Virus IgG Antibody test demonstrating immunity.</td>
</tr>
<tr>
<td></td>
<td>Copy of laboratory report must be attached.</td>
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</tr>
</tbody>
</table>

REQUIRED ONLY FOR STUDENTS TAKING 9 OR MORE TCNJ CREDITS THEIR 1ST SEMESTER/TERM.

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Date 1 Requirement</th>
<th>Date 2 Requirement</th>
<th>Date 3 Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 doses of HEPATITIS B VACCINE</td>
<td>Dose 1: <em><strong><strong>/</strong></strong></em>/______ M   D   Y</td>
<td>Dose 1: <em><strong><strong>/</strong></strong></em>/______ M   D   Y</td>
<td>Dose 1: <em><strong><strong>/</strong></strong></em>/______ M   D   Y</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>3 doses of Combined HEPATITIS A &amp; HEPATITIS B VACCINE</td>
<td>Dose 2: <em><strong><strong>/</strong></strong></em>/______ M   D   Y</td>
<td>Dose 2: <em><strong><strong>/</strong></strong></em>/______ M   D   Y</td>
<td>Dose 2: <em><strong><strong>/</strong></strong></em>/______ M   D   Y</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>LABORATORY PROOF OF DISEASE OR IMMUNITY TO HEPATITIS B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copy of laboratory report must be attached.</td>
<td>Copy of laboratory report must be attached.</td>
<td>Copy of laboratory report must be attached.</td>
</tr>
</tbody>
</table>

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)

Page 4
TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

To be completed and signed by the student. Upload into OWL under Tuberculosis (TB) Screening Questionnaire.

Name: _______________________________ Birth date: ___/___/_____ PAWS ID: ______________________

Last M            D            Y First

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

Afghanistan Colombia Iraq Mongolia Singapore
Algeria Comoros Kazakhstan Montenegro Solomon Islands
Angola Congo Kenya Morocco Somalia
Anguilla Côte d’Ivoire Kiribati Mozambique South Africa
Argentina Democratic Republic of the Congo Korea (Democratic People’s Republic of) Namibia Sri Lanka
Armenia Azerbaijan Djibouti Korea (Republic of) Nauru Sudan
Bangladesh Dominican Republic Kuwait Nepal Suriname
Belarus Ecuador Kyrgyzstan New Caledonia Swaziland
Belize El Salvador Lao People’s Democratic Republic Nicaragua Syrian Arab Republic
Benin Equatorial Guinea Mongolia Niger Tajikistan
Bhutan Eritrea Latvia Nigeria Tanzania (United Republic of)
Bolivia (Plurinational State of) Botswana Brazil Bulgaria Burkina Faso Burundi Cabo Verde Cambodia Cameroon Central African Republic Chad China (including Taiwan) China, Hong Kong SAR China, Macao SAR

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. 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. TAKE THIS FORM (page 5) 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.
PHYSICIAN’S EVALUATION FOR TUBERCULOSIS

Student’s Name: _____________________________________________________________

Birth date: _____/_____/______

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: _____/_____/______

   Chest X-Ray Date: _____/_____/______ (Copy of Radiologist’s report in ENGLISH must be attached) Result: Normal ☐ Abnormal ☐

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

   Treatment: __________________________________________________ Completed successfully on _____/_____/______

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 (REQUIRED): ______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 ☐

   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)