TCNJ PRE-ENTRANCE HEALTH REQUIREMENT PACKET

Please Print and Read Carefully!

DUE DATE FOR COMPLETION:

Fall entering: JULY 15th
Winter entering: NOVEMBER 15th
Spring entering: JANUARY 15th
Summer entering: MAY 20th

Failure to complete health requirements by the due date will result in the following:
Registration hold
Placement on the "No-Move In list for college housing (if applicable)
Late fees

REQUIRED HEALTH FORMS

1. AUTHORIZATION TO TREAT A MINOR (PAGE 4 OF THIS PACKET)

Required ONLY for students who will be under age 18 when they arrive on campus.

2. RECORD OF IMMUNIZATION (PAGES 5 & 6 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; an Immunization Record from your doctor, employer, military or previous school, can be substituted and uploaded into OWL. Just be sure that it contains all the TCNJ required vaccinations.
- ☐ Be sure to obtain any required vaccinations that you are missing. If your doctor does not have the vaccine(s) that you need, or you cannot see your doctor before the due date, go elsewhere! This is not excuse for missing the due date and you will incur holds. Some countries may not have the vaccinations required at TCNJ. If this is the case, please email health@tcnj.edu to obtain an extension and arrange for vaccination in TCNJ Student Health Services upon arrival. *Students who are completing vaccination series such as Hepatitis B where spacing between doses is necessary can obtain an extension from Student Health Services.*

Continued on next page

3. TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (PAGE 7 OF THIS PACKET)

4. PHYSICIAN'S EVALUATION FOR TUBERCULOSIS (PAGE 8 OF THE PACKET)

Required ONLY if you answered YES to one or more questions on the Tuberculosis (TB) Screening Questionnaire:

- ☐ Schedule an appointment with your doctor for TB testing and evaluation.
- ☐ Have your healthcare provider complete the Physician's Evaluation for Tuberculosis form.

This form is NOT required if you answered NO to ALL questions on the Tuberculosis (TB) Screening Questionnaire.

WHERE & HOW TO SUBMIT HEALTH FORMS

1. Log into **OWL** (Online Wellness Link) at https://tcnj.medicatconnect.com/ using your TCNJ email username and password. (Fall entering students will be able to log in to OWL after May 15th)
2. Click on the "Forms" tab. Scroll down to "Pre-Entrance Health Requirements". Click on "NEW STUDENT MEDICAL HISTORY". Complete this form and click "Submit".
3. Click on the "Immunizations" tab, then on "Enter Dates". Using the TCNJ Record of Immunization form (page 5 & 6) as a guide, manually type in the dates of your immunizations. If you are submitting laboratory immunity testing in place of vaccination dates, leave the spaces blank. When finished, click "Submit".
4. Click on the "Upload" tab and follow the instructions. Upload all completed forms & health records.
5. When all steps have been completed, your records will be queued for review by the Immunization Compliance Specialist. When this review is complete, an email will be sent to your TCNJ EMAIL ACCOUNT. You will informed if your requirements are complete or incomplete. Be sure to monitor your TCNJ email account frequently.

International students having difficulty logging into OWL or uploading documents can email them to health@tcnj.edu .

A Word About Scanning Documents for Upload Into OWL

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).

MENINGOCOCCAL DISEASE AND VACCINATION INFO SHEET

NEW JERSEY STATE LAW REQUIRES THAT COLLEGES PROVIDE ALL INCOMING STUDENTS WITH INFORMATION ABOUT MENINGITIS INFECTION AND VACCINATION. STUDENTS WILL THEN BE ASKED A QUESTION ON THE 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, 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 given at age 16 years to provide protection when meningococcal meningitis incidence peaks (16-21 years of age).

It is also recommended that teens and young adults (16 through 23 year olds) are 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.

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 ON OR AFTER AGE 16. Men B vaccine is recommended but NOT required.

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

TCNJ THE COLLEGE OF NEW JERSEY
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 (print): _____ Birth date: _____/_____/_____
Last *First* *M* *D* *Y*

_____ _____
[Print name of parent/legal guardian] [Signature of parent/legal guardian]

_____ _____
[Relationship to student] [Date]

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)

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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.

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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.

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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 TDAP VACCINE RECEIVED AFTER 11TH BIRTHDAY & AFTER 2005: _____/_____/_____ *M D Y* **Vaccine MUST INCLUDE PERTUSSIS.**

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 AT OR AFTER AGE 16: **Most recent dose:** _____/_____/_____ *M D Y*

Trade Name: ☐ Nimenrix® ☐ Mencevax® ☐ Other ACYW:_____ *Unknown brand ACYW:* _____

NOTE: Vaccine MUST contain serogroups A, C, Y, and W-135

DOCTOR: Give Booster dose if doses received BEFORE age 16 to continue protection during age of highest risk (16-21 years)

RECOMMENDED VACCINES (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, NP or RN

Print Name & Title: _____

Signature: _____

Date: _____ Office Telephone: ( ) _____

Not valid without Office Stamp (REQUIRED)

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 *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 Tuberculosis (TB)? ..... ☐ yes ☐ no

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

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
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)
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Congo (Democratic Republic of)
Côte d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Korea (Democratic People's Republic of)
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
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Romania
Russian Federation
Rwanda
Sao Tome & Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
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 2015. Countries with TB incidence rates of ≥ 20 cases per 100,000 population.

4) Have you had any **frequent** (every year or less) OR **prolonged** visits of 30 days or more to one or more of the countries listed above? If yes, please CHECK the countries or territories, above..……..... ☐ 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 healthcare professional or volunteer 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: medically underserved, low-income, drug addict/ alcoholic?.. ☐ yes ☐ no

I verify that the information provided by me on this form is true. _____ **Date**_____
Student's signature

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.

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.

Only required if the student has answered YES to one or more questions on PAGE 7, 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 healthcare provider.

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 (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 ☐
   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)