



TCNJ PRE-ENTRANCE HEALTH REQUIREMENT PACKET FOR FIRST-YEAR & TRANSFER STUDENTS

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
EOF Summer entering: JUNE 9th

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. *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 be informed if your requirements are complete or incomplete. Be sure to monitor your TCNJ email account frequently.

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). 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.**

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>



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: _____
Last First

Birth date: ____/____/____
M D Y

REQUIRED FOR ALL UNDERGRADUATE STUDENTS:

MEASLES, MUMPS, RUBELLA (MMR) (students born BEFORE 1957 are exempt from the MMR requirement)			
<p>OR →</p> <p>↓</p>	<p>2 doses of MMR VACCINE</p> <p>Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>	<p>OR</p>	<p>LABORATORY PROOF OF IMMUNITY (see below)</p> <p style="text-align: center;">↓</p>
<p>2 doses of MEASLES VACCINE</p> <p>Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>		<p>OR</p>	<p>MEASLES Virus IgG Antibody test demonstrating immunity.</p> <p>Copy of laboratory report must be attached.</p>
<p>2 doses of MUMPS VACCINE</p> <p>Dose 1 RECEIVED ≥ 12 MONTHS OF AGE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>		<p>OR</p>	<p>MUMPS Virus IgG Antibody test demonstrating immunity.</p> <p>Copy of laboratory report must be attached.</p>
<p>1 dose of RUBELLA VACCINE</p> <p>Dose 1 RECEIVED ≥ 12 MONTHS OF AGE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>		<p>OR</p>	<p>RUBELLA Virus IgG Antibody test demonstrating immunity.</p> <p>Copy of laboratory report must be attached.</p>
VARICELLA (Chickenpox)			
<p>2 doses of VARICELLA VACCINE</p> <p>Dose 1 RECEIVED ≥ 12 MO OF AGE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>	<p>OR</p>	<p>LABORATORY PROOF OF IMMUNITY</p> <p>Varicella Zoster Virus (VZV) IgG Antibody test.</p> <p>Copy of laboratory report must be attached.</p>	<p>History of Chickenpox Infection</p> <p>Date: ____/____/____ <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p><i>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.</i></p>
TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)			
<p>1 dose of TDAP VACCINE RECEIVED AFTER 11TH BIRTHDAY & AFTER 2005: ____/____/____ <u>Vaccine MUST INCLUDE PERTUSSIS.</u> <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>			

Continued on next page

Student's Name: _____
Last First

Birth date: ____/____/____
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 ON OR AFTER AGE 16:

Most recent dose: ____/____/____
M D Y

U.S. Brand: Menactra® (Sanofi) Menveo® (Glaxo) Unknown brand

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

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: ____/____/____
M D Y M D Y M D Y

Which one: _____

MEN B VACCINE (Meningococcal meningitis B)

Dose 1: ____/____/____ Dose 2: ____/____/____ Dose 3: ____/____/____
M D Y M D Y M D Y

Which one: Bexero® (Sanofi) Trumenba® (Pfizer)

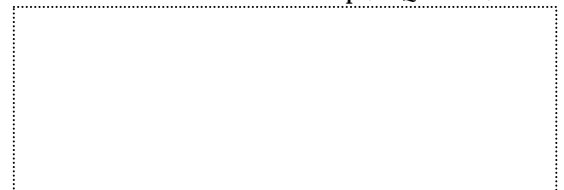
Record of Immunization is NOT VALID unless signed & stamped by a PHYSICIAN, PA, NP or RN

Print Name & Title: _____

Signature: _____

Date: _____ Office Telephone: () _____

Not valid without Office Stamp (REQUIRED)



**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)