THE COLLEGE OF NEW JERSEY
STUDENT HEALTH SERVICES

Pre-Entrance Health Requirement Packet
Career & Community Studies Students

Due Date: JULY 15

Steps to Complete Health Requirements

①

FORMS FOR THE STUDENT TO DO

- ✓ **Student:** read page 3: **Meningococcal Disease for College Students**
- ✓ **Student:** print out and fill out the following forms. Then UPLOAD them into the Online Wellness Link, **OWL**, at https://tcnj.medicatconnect.com/:
  ---Page 1: **Tuberculosis (TB) Screening Questionnaire**
  ---Page 4: **Meningococcal Vaccination Requirement Questionnaire**

②

FORMS FOR YOUR HEALTHCARE PROVIDER TO DO

- ✓ Page 2: **Physician's Evaluation for Tuberculosis**. This form is required if you answered YES to one or more questions on the Tuberculosis Screening Questionnaire. Schedule an appointment with your healthcare provider. Once this form is complete, UPLOAD this form and any accompanying documents into OWL.

- ✓ Page 5-6: **Record of Immunization**: You are not required to use our form. An official record from your healthcare provider, pharmacist, previous school, military, or employer can be submitted in place of our form. However use our form as a guide to determine which vaccines are required for YOU. Be sure to let your healthcare provider know that new meningitis vaccination requirements in N.J. may require YOU to be vaccinated against either Men ACWY or Men B, or both (refer to the **Meningococcal Vaccination Requirement Questionnaire (page 4) that you completed.**

Continued on next page

③

LOG INTO OWL at https://tcnj.medicatconnect.com/

- ✓ **Student:** Select FORMS. Scroll down to the section, "Pre-Entrance Health Requirements". Then select **Student Medical History** and complete (this is an electronic form). You may need some help from your family to answer the questions accurately. Your answers are confidential and only visible to the Student Health Services' clinical staff.
- ✓ **Student:** Click on the "Immunizations" tab. 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 test results in place of vaccination dates, leave the spaces blank. When finished, click "Submit".
- ✓ **Student: Upload your completed health forms**. Select the UPLOAD tab and follow the instructions.

④

STUDENT: CHECK YOUR TCNJ EMAIL ACCOUNT!

Student: Your job now is to check your TCNJ email account every couple of days for an email from Student Health Services. This email will inform you that your health requirements are either complete or incomplete. Expect to receive this email within 5 days after submitting health requirements. **Do not assume that you have completed health requirements until you receive an email informing you of this!**

If you have any questions or are having problems with the health requirements, PLEASE let us know. Email our office at health@tcnj.edu.

Missing Vaccinations? Most insurance plans cover required and recommended vaccines. If you are under 19 years of age, ask your healthcare provider if they participate in your state's Vaccines for Children (VFC) Program. You may qualify for free or low-cost vaccines. You can also check with local health departments, pharmacies, and urgent care centers.

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

To be completed and signed by the student. Upload into OWL under Tuberculosis 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 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** (every year or more often) OR a **prolonged visit (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 court-appointed legal guardian if applicable)*

Afghanistan
Albania
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
Côte d'Ivoire
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
French Polynesia
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
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Romania
Russian Federation
Rwanda
Sao Tome & Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Taiwan
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Vietnam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2017. 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 healthcare provider to complete the "Physician's Evaluation for Tuberculosis" on the next page. TAKE THIS FORM (page 3) 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. Upload this form into OWL.

THE COLLEGE OF NEW JERSEY
STUDENT HEALTH SERVICES

This form is required if the student has answered YES to one or more questions on PAGE 1, 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 <u>within 6 months</u> 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 ☐ **<u>Copy of laboratory report must be attached.</u>**
     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

Office Stamp (REQUIRED)

Print Name & Title: _____

Signature: _____

Date: _____ Office Telephone: ( ) _____

Meningococcal Disease for College Students

New Jersey law requires that certain students receive meningococcal vaccines!

Are you protected?

Students attending college are at higher risk of getting meningococcal disease, especially first-year students living in residence halls.

Get vaccinated!

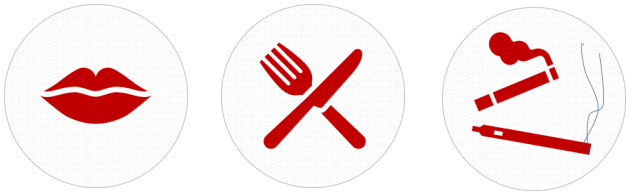
What is meningococcal disease?

Meningococcal (muh-nin-jo-cok-ul) disease is a serious bacterial infection caused by *Neisseria meningitidis*. The bacteria can invade the body, leading to severe swelling of the tissue surrounding the brain and spinal cord (meningitis) or bloodstream infection. Both of these types of infections are very serious and can be deadly in a matter of hours. Even with antibiotic treatment, 10 to 15 in 100 people infected with meningococcal disease will die. Up to 1 in 5 survivors will have long-term disabilities, such as loss of limb(s), deafness, nervous system problems, or brain damage.

How do people get meningococcal disease?

People spread meningococcal bacteria by sharing respiratory and throat secretions (saliva/spit). Generally, the bacteria are spread by close or lengthy contact with a person who has meningococcal disease such as:

- People in the same household
- Roommates
- Anyone with direct contact with the patient's oral secretions such as through kissing or sharing eating utensils, cigarettes/vaping devices, and food.



What are the symptoms of meningococcal disease?

Symptoms can progress quickly and may include:

- high fever
- headache
- stiff neck
- confusion
- sensitivity to light
- nausea
- vomiting
- exhaustion
- purplish rash

Some people carry the bacteria in their noses and throat, but they don't become ill. Even though they do not have symptoms, they can still spread the bacteria to others.

How can I protect myself from meningococcal disease?

The best way to protect yourself from meningococcal disease is to **get vaccinated**. There are two types of meningococcal vaccines that protect against the common serogroups (A, B, C, W, Y) of the bacteria:

- Meningococcal conjugate or MenACWY vaccines (Menveo® or Menactra®)
- Serogroup B meningococcal or MenB vaccines (Bexsero® or Trumenba®)

For more information, please visit https://nj.gov/health/cd/topics/meningo.shtml, or contact the NJDOH Vaccine Preventable Disease Program at 609-826-4861.

MENINGOCOCCAL VACCINATION REQUIREMENT QUESTIONNAIRE

As a new student enrolling in a public or private institution of higher education in New Jersey, you are required by state law (P.L.2019, C.332 (N.J.S.A 18A:62-15.1) to receive meningococcal vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) as a condition of college attendance.

There are 2 types of meningococcal vaccines available in the United States:

- Meningococcal Meningitis ACWY (MenACWY) vaccines (Brand names are Menactra® and Menveo®): Routinely received at ages 11-12 years with a booster dose at 16 years. Adolescents who receive their first dose of MenACWY on or after their 16th birthday do not need a booster dose. Additional doses may be recommended based on risk. People 19 years of age and older are not routinely recommended to receive the MenACWY vaccine unless they are living in college housing or if another risk factor applies.
- Meningococcal Meningitis B (MenB) vaccines (Brand names are Bexsero® and Trumenba®): Routinely recommended for people ages 10 years and older with high-risk health conditions. People 16-23 years old (preferably at ages 16-18 years) may also choose be vaccinated against MenB.

To find out what type of meningococcal meningitis vaccine(s) you will need to attend TCNJ, please answer the following questions. Be sure to show this form to your healthcare provider so that these vaccinations can be noted on your record of vaccination.

You will need <u>Meningococcal Meningitis ACWY</u> vaccination if you answer YES to one or more of the age and risk factor questions below.

1. Are you 18 years of age or younger? ☐ yes ☐ no
2. Are you 19 years of age or older and plan to apply for college housing? ☐ yes ☐ no
3. Do you have a rare type of immune disorder called complement component deficiency or Human Immunodeficiency Virus (HIV)? ☐ yes ☐ no
4. Are taking a type of medicine called a complement inhibitor (for example, Soliris® or Ultomiris®) ☐ yes ☐ no
5. Has your spleen been removed or do you have a damaged spleen, including sickle cell disease? ☐ yes ☐ no

You will need <u>Meningococcal Meningitis B</u> vaccination if you answer YES to one or more of the risk factor questions below.

1. Do you have a rare type of immune disorder called complement component deficiency? ☐ yes ☐ no
2. Are taking a type of medicine called a complement inhibitor (for example, Soliris® or Ultomiris®)? ☐ yes ☐ no
3. Has your spleen been removed or do you have a damaged spleen – including sickle cell disease? ☐ yes ☐ no

I verify that the information provided by me on this form is true. _____ Date_____
Student's signature (or court-appointed legal guardian if applicable)

Though Meningococcal Meningitis B vaccination is not required for persons 16-23 years of age, you may choose to receive Men B vaccine to provide short-term protection against most strains of Men B disease. Learn more about meningococcal disease and Men B vaccination at www.cdc.gov/meningococcal. Please consult with your healthcare provider if you have questions about the meningococcal vaccines or if you need to receive the vaccines to attend TCNJ.

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

To be completed and signed by the student. Upload this form into OWL under Meningococcal Vaccination Requirement Questionnaire.

PEHRP 5/2020

RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY

This form does not have to be used. An official immunization record from your healthcare provider, pharmacist, previous school, military, or employer can be submitted in place of this form.

Student's Name: (last)	(first)	Birth date:
Cell phone #	PAWS ID:	I will reside in college housing: ___ Yes ____No
	I	

The rest of this form is to be completed, signed and office stamped by a physician, nurse practitioner, physician assistant or registered nurse.

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

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

VARICELLA (Chickenpox) Requirement

2 doses of VARICELLA VACCINE REQUIRED Dose #1 RECEIVED ≥ 12 MO OF AGE: _____/_____/_____ M D Y Dose #2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:_____/_____/_____ M D Y	**OR**	**LABORATORY DOCUMENTATION OF IMMUNITY** **Varicella Zoster Virus (VZV) IgG Antibody test.** **Copy of laboratory report must be attached.**	**OR**	**History of Chickenpox Infection or history of herpes zoster, based on healthcare provider diagnosis** Date: _____/_____ M Y

TETANUS, DIPHTHERIA, PERTUSSIS vaccination (Tdap): Required

1 dose of TDAP VACCINE RECEIVED WITHIN THE PAST 10 YEARS IS REQUIRED (i.e. Adacel®; Boostrix®): _____/_____/_____ M D Y

Continued on next page

Student's Name: _____ Birth date: _____/_____/_____

Last *First* *M D Y*

HEPATITIS B vaccination: Required for full-time students (full-time = 3 or more course units/semester). NOTE: If starting vaccination series, no need to accelerate dosing. Series can be completed at TCNJ)

3-4 doses of Hepatitis B vaccine Engerix-B® (GSK), Recombivax HB® (Merck) depending on schedule used.

Dose #1: _____/_____/_____ *M D Y*

Dose #2: _____/_____/_____ *M D Y*

Dose #3: _____/_____/_____ *M D Y*

Dose #4: _____/_____/_____ *M D Y*

OR

2 doses of Recombinvax-HB® (Merck) Hepatitis B vaccine licensed for a 2-dose schedule only for children aged 11–15 years.

Dose #1: _____/_____/_____ *M D Y*

Dose #2: _____/_____/_____ *M D Y*

OR

2 doses of Heplisav-B® (Dynavax)

Dose #1: _____/_____/_____ *M D Y*

Dose #2: _____/_____/_____ *M D Y*

OR

3-4 doses of Combined HEPATITIS A & HEPATITIS B VACCINE (Twinrix®) depending on schedule used.

Dose #1: _____/_____/_____ *M D Y*

Dose #2: _____/_____/_____ *M D Y*

Dose #3: _____/_____/_____ *M D Y*

Dose #4: _____/_____/_____ *M D Y*

MEN ACWY vaccination (Menactra®; Menveo®): Required for all students who 1) are 18 years of age and younger, 2) are 19 years of age and older and applying to live in college housing, 3) have medical risk factors: anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement deficiency, or complement inhibitor use (e.g. Solaris®, Ultomiris®).

One dose received AT OR AFTER AGE 16 is REQUIRED for students without medical risk factors noted above:

_____/_____/_____ *M D Y*

Previous dose at 10-15 years of age? ____/_____/_____ *M D Y*

OR

Required for students with the above medical risk factors:

Primary dose #1: _____/_____/_____ *M D Y* **Primary dose #2:** _____/_____/_____ *M D Y*

If 5 years from dose #2, revaccinated on _____/_____/_____ *M D Y*

MEN B vaccination (Trumenba®; Bexero®): Required for students have medical risk factors: anatomical or functional asplenia (including sickle cell disease), persistent complement deficiency, or complement inhibitor use (e.g. Solaris®, Ultomiris®). OPTIONAL for all other students.

MenB-FHbp (Trumenba®, Wyeth)

Dose #1: _____/_____/_____ *M D Y* **Dose #2:** _____/_____/_____ *M D Y*

Dose #3: _____/_____/_____ *M D Y*

OR

MenB-4C (Bexsero®, Novartis)

Dose #1: _____/_____/_____ *M D Y* **Dose #2:** _____/_____/_____ *M D Y*

HEPATITIS A vaccination (Havrix®; Vaqta®) RECOMMENDED

Dose #1: _____/_____/_____ *M D Y* **Dose #2:** _____/_____/_____ *M D Y*

HUMAN PAPILLOMAVIRUS (HPV) vaccination RECOMMENDED

Dose #1: _____/_____/_____ *M D Y* **Dose #2:** _____/_____/_____ *M D Y* **Dose #3 if administered at or after age 15 years:** _____/_____/_____ *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)