PRE-ENTRANCE HEALTH REQUIREMENT PACKET

Undergraduate Students

Due Dates for Completion

EOF Summer Program	June 9
Fall entering students	July 15
Winter entering students	Nov 15
Spring entering students	Jan 15
Summer entering students	May 20

Please note: Failure to complete health requirements by the due date will result in the following:
Registration hold, Late Fines, Housing hold
Possible deregistration from classes

Steps to Completing Health Requirements

STEP 1:

FORM THAT YOU, THE STUDENT, COMPLETES IN OWL

New Student Medical History. This form is not in this Packet. It is an ONLINE form located in the "FORMS" section of the health portal, OWL (https://tcnj.medicatconnect.com/). Responses are confidential and viewed only by Student Health Services.

STEP 2:

FORMS IN THE PACKET TO TAKE TO YOUR DOCTOR

- **Record of Immunization**: This form is in this Packet. You are not required to use our form, but we prefer that you do. You can substitute our form with an official record from your doctor's office, previous school, pharmacist, armed forces, or employer. If not using our form, do not upload it.

  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, please go elsewhere (e.g., local pharmacy, urgent care, walk-in clinic). This is not an acceptable excuse for missing the due date and you will incur holds and fines.

- **Physician's Evaluation for Tuberculosis**. This form is in this Packet. It is required to be completed and uploaded **ONLY** if you answered YES to one or more questions on the TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE in the New Student Medical History in OWL. Schedule an appointment with a healthcare provider. Once this form is complete, UPLOAD this form and any accompanying documents to OWL. If you answered NO to all TB Screening Questions, this form is not required.

Continued

STEP 3:

FORM IN THE PACKET FOR PARENT OR LEGAL GUARDIAN TO COMPLETE

Authorization to Treat a Minor. This form is in this Packet. It is to be completed and uploaded ONLY if you, the student, will be 17 years of age or younger when you arrive on campus. Only upload if completed.

STEP 4:

UPLOAD COMPLETED FORMS TO OWL: https://tcnj.medicatconnect.com/

- Select the UPLOAD tab and follow the instructions to upload your health forms. Do not upload blank forms.

- Select the "IMMUNIZATION" tab. Using the Record of Immunization form 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". Remember that your immunization records must still be uploaded to OWL to verify the dates your entered.

STEP 5:

STUDENT, CHECK YOUR TCNJ EMAIL ACCOUNT!

Your job now is to check your TCNJ email account every couple of days for an email from Student Health Services. This is how we communicate with you. We will inform you that your health requirements are either complete or incomplete and why. Sometimes we can't open the form you uploaded to review it. If you don't check TCNJ email, you will be unaware that there is a problem and you will incur holds and fines. Expect to receive this email within 7 days after submitting health requirements. The email may instruct you to log in to OWL to read your message from our office.

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

RECORD OF IMMUNIZATION FOR THE COLLEGE OF NEW JERSEY

You are not required to use this form. However, it is important that you use it as a guide to required vaccinations.
An official immunization record from your healthcare provider, pharmacist, previous school, armed forces, or employer can be substituted.

Student's Name: (last)	**(first)**	**Birth date:** _____/_____/_____ M D Y
Student's cell phone #:	**PAWS ID #:**	**Starting Term: ___Fall ___Winter ___Summer ___EOF ___Spring**
I will reside on campus: ___Yes ___No	**I will be a full-time student (taking 3 or more course units per semester): ___Yes ___No**	

The rest of this form is to be completed, signed, and <u>office-stamped</u> by a physician, nurse, or physician assistant.

MEASLES, MUMPS, RUBELLA (MMR). REQUIRED. (note: student 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 28 DAYS or more after Dose 1: _____/_____/_____ M D Y	**OR**	**LABORATORY TEST REPORT of IMMUNITY** (see below) ↓
	2 doses of MEASLES VACCINE Dose #1 RECEIVED AFTER 1968 AND at or after 12 MONTHS OF AGE: _____/_____/_____ M D Y Dose #2 RECEIVED 28 DAYS or more after Dose 1: _____/_____/_____ 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 28 DAYS or more after Dose 1: _____/_____/_____ M D Y	**OR**	MUMPS Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
	1 dose of RUBELLA VACCINE 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). REQUIRED.

2 doses of VARICELLA VACCINE Dose #1 RECEIVED at or after 12 MO OF AGE: _____/_____/_____ M D Y Dose #2 RECEIVED 28 DAYS or more after Dose 1: _____/_____/_____ M D Y	**OR**	**LABORATORY PROOF OF IMMUNITY** Varicella Zoster Virus (VZV) IgG Antibody test. Copy of laboratory report must be attached.	**OR**	**PAST HISTORY** of Chickenpox or herpes ZOSTER (Shingles) based on healthcare provider diagnosis. Date: _____/_____/_____ M D Y

COVID-19 vaccination: Primary Series. REQUIRED.					**COVID-19 Booster. RECOMMENDED.**
Pfizer-Biotech (Comirnaty®) Dose #1: _____/_____/_____ M D Y Dose #2: _____/_____/_____ M D Y	**OR**	**Moderna (Spikevax®)** Dose #1: _____/_____/_____ M D Y Dose #2: _____/_____/_____ M D Y	**OR**	**J&J/Janssen** One Dose: _____/_____/_____ M D Y	**Most recent booster if more than one booster received:** _____/_____/_____ M D Y ☐ Pfizer ☐ Moderna ☐ J&J/Janssen

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap or Td) vaccination. REQUIRED.

1 dose of TDAP or TD VACCINE RECEIVED within the last 10 years: _____/_____/_____ M D Y **Tdap** ☐ **Td** ☐

PEHR 5/1/22

Continued on next page

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

HEPATITIS B. REQUIRED FOR FULL-TIME STUDENTS (Full-Time = 3 or more course units/semester). NOTE: If starting vaccination series, vaccinations can be completed at TCNJ; no need to accelerate doses.

3-4 doses of Hepatitis B vaccine Engerix-B® (GSK) or Recombivax HB® (Merck) depending on schedule used. Dose #1: ____/____/____ (M D Y) Dose #2: ____/____/____ Dose #3: ____/____/____ Dose #4: ____/____/____	**OR**	**2 doses of Recombivax HB® (Merck) Hepatitis B vaccine licensed for a 2-dose schedule for children aged 11-15 years only.** Dose #1: ____/____/____ (M D Y) Dose #2: ____/____/____	**OR**	**2 doses of Heplisav-B® (Dynavax)** Dose #1: ____/____/____ (M D Y) Dose #2: ____/____/____	**OR**	**3-4 doses of Combined HEPATITIS A & B VACCINE (Twinrix®) depending on schedule used.** Dose #1: ____/____/____ (M D Y) Dose #2: ____/____/____ Dose #3: ____/____/____ Dose #4: ____/____/____

MENINGOCOCCAL ACWY vaccination (Menactra®; Menveo®). REQUIRED

One dose received AT OR AFTER AGE 16 is REQUIRED for all students who are • **18 years of age and younger** • **19 years of age and older applying to live in college housing** **Dose received at or after age 16:** ____/____/____ (M D Y) Previous dose received at 10-15 years of age? ____/____/____ (M D Y)	**OR**	**For students with medical risk factors: anatomical or functional asplenia, sickle cell disease, HIV infection, persistent complement deficiency, or complement inhibitor use (e.g., Solaris®, Ultomiris®):** 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®, Bexsero®). REQUIRED only for students who have certain medical risk factors: anatomical or functional asplenia, sickle cell disease, HIV infection, persistent complement deficiency, or complement inhibitor use (e.g., Solaris®, Ultomiris®).

MenB-FHBP (Trumenba®, Wyeth) Dose #1: ____/____/____ (M D Y) Dose #3: ____/____/____ (M D Y) Dose #2: ____/____/____ (M D Y)	**OR**	**MenB-4C (Bexsero®, Novartis)** Dose #1: ____/____/____ (M D Y) Dose #2: ____/____/____ (M D Y)

HEPATITIS A vaccination (i.e., 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)

PHYSICIAN'S EVALUATION FOR TUBERCULOSIS

Completion of this form by a physician, PA or NP is REQUIRED only if you (the student) answered YES to one or more questions on the Tuberculosis Screening Questionnaire in the NEW STUDENT MEDICAL HISTORY in OWL.
Completion of this form REQUIRES an office visit to a healthcare provider and then must uploaded to OWL.

Student's Name: _____ **Birth date:** ____/____/____ **I start TCNJ classes on** _____.
Last *First* *M D Y*

Healthcare provider: Your patient has identified risk factors on a college screening questionnaire that places them at higher risk for TB infection and disease. Please complete the following evaluation.

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 **no sooner than 6 months before the start of school:**

- **Preferred Method:** Interferon Gamma Release Assay (IGRA): ____/____/____ Neg ☐ Pos ☐ **Lab report must be provided.**
  M D Y

OR

- TB Skin Test placed: ____/____/____ TB Skin Test read: ____/____/____ Result **in mm**: _____mm Interpret: Neg ☐ Pos ☐
  M D Y *M D Y*

5. If TB Test is positive, CHEST X-RAY is required. Radiologist's report of findings must be provided.

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

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

Latent Tuberculosis Infection Resources & Treatment Guidelines for Providers are available at https://www.cdc.gov/tb/publications/ltbi/ltbiresources.htm

---

Office Stamp (REQUIRED)

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

Print Name & Title: _____

Signature:_____

Date: _____ Office Telephone: ( )_____

TCNJ THE COLLEGE OF NEW JERSEY
Student Health Services

AUTHORIZATION TO TREAT A MINOR

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

I hereby authorize Student Health Services at The College of New Jersey to provide medical and therapeutic care to my minor child, including but not limited to, diagnostic examinations such as laboratory testing, tuberculosis screening, and 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] [Signature of parent]

_____ _____
[Relationship to student] [Date]

EMERGENCY CONTACT INFORMATION:

Parents often ask how to provide TCNJ with their emergency contact information. The centralized location for this information is PAWS.

Students can add and update their emergency contact information following the instructions found at https://pawshelp.tcnj.edu/undergraduate-students/current-students/ (scroll down to the bottom of the page). It is important that this information is added before the student arrives on campus and that it is kept up-to-date.