# TCNJ PRE-ENTRANCE HEALTH REQUIREMENT PACKET
# FOR GRADUATE STUDENTS

***Please Print and Read Carefully!***

**TCNJ 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.**

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

  ☐ This electronic form is completed online in OWL (https://tcnj.medicatconnect.com/). After logging in to OWL, select the "FORMS" tab at the top of the screen and scroll down to the section, TCNJ Pre-Entrance Health Requirements. Select New Student Medical History.

- **TUBERCULOSIS (TB) SCREENING QUESTIONNIARE (PAGE 1)**

  ☐ Answer questions 1-7. **Sign and date the form**.

  ☐ Upload this form into OWL. Select the **Upload** tab and follow the instructions.

- **PHYSICIAN'S EVALUATION FOR TUBERCULOSIS (PAGE 2)**

  This form is **ONLY** required if you answered YES to one or more questions on the Tuberculosis (TB) Screening Questionnaire (page 1).

  ☐ 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 this form into OWL. Select the **Upload** tab and follow the instructions.

- **MENINGOCOCCAL DISEASE FOR COLLEGE STUDENTS (PAGE 3)** – Please read this important information from the N.J. Department of Health for people of all ages.

CONTINUED ON NEXT PAGE.

- **MENINGOCOCCAL VACCINATION REQUIREMENT QUESTIONNAIRE (PAGE 4)**

  ☐ Answer all 8 questions on the form. **Sign and date the form**.

  ☐ If you answered YES to one or more of the questions on this form, you are required by N.J. higher education state law to be vaccinated against meningococcal meningitis ACWY or B, or both. Please schedule an appointment with your healthcare provider to obtain vaccination or a record that you have received vaccination and upload the record into OWL. If you have any questions, please let us know (email health@tcnj.edu).

- **RECORD OF IMMUNIZATION (PAGE 5)**

  ☐ Take this form to your healthcare provider to be completed, signed, and office-stamped. All required vaccination fields must be complete. You are not required to use our form. You can submit an immunization record from your previous school, medical office, employer, pharmacist, or United States Armed Forces indicating compliance with TCNJ immunization requirements.

  ☐ 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.

  ☐ Then log into OWL and select the **Immunization** tab. Manually type in the dates of your immunizations. If you are submitting laboratory test records instead of vaccination records, you do not enter any information on the Immunization page

  ☐ While still in OWL, select the **Upload** tab and follow the instructions to upload your record of immunization into OWL. If you have laboratory immunity test records, you can upload them as well.

# 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 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) <u>OR</u> 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

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 1) and the Physician's Evaluation for Tuberculosis (page 2) WITH YOU TO YOUR APPOINTMENT.**

**If you answered <u>NO to all of the above questions</u>, 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 3, 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: ______________________________

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

Print Name & Title: ______________________________________________

Signature:______________________________________________

**Date:** ____________ Office Telephone: ( )______________________

Office Stamp (REQUIRED)

# 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!**

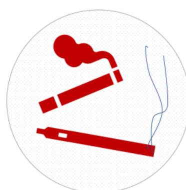
## What is meningococcal disease?

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.

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

**To be completed, signed and dated by the student. Upload this form into OWL under Meningococcal Vaccination Requirement Questionnaire. If vaccination is indicated, obtain a record of vaccination from your doctor or pharmacist and upload the record into OWL.**

## MENINGOCOCCAL VACCINATION REQUIREMENT QUESTIONNAIRE

As a 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 as listed below.**

- 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) (if any) you will need to attend TCNJ, please answer the following:

**You will need Meningococcal Meningitis ACWY 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 or Human Immunodeficiency Virus (HIV)? ☐ yes ☐ no
2. Are taking a type of medicine called a complement inhibitor (e.g., Soliris® or Ultomiris®)? ☐ yes ☐ no
3. Has your spleen been removed or damaged? ☐ yes ☐ no
4. Do you have sickle cell disease? ☐ yes ☐ no

**You will need Meningococcal Meningitis B 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 (e.g., Soliris® or Ultomiris®)? ☐ yes ☐ no
3. Has your spleen damaged or had it been removed, or do you have sickle cell disease? ☐ yes ☐ no
4. Has your spleen been removed or damaged? ☐ yes ☐ no
5. Do you have sickle cell disease? ☐ yes ☐ no

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

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. Obtain a record of these immunizations, if required, and upload the record into OWL.

# 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)

| | | | |
|---|---|---|---|
| OR → ↓ | 2 doses of MMR VACCINE<br>Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE: _____/______/______ *M D Y*<br>Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: _____/______/______ *M D Y* | OR | LABORATORY PROOF OF IMMUNITY (see below) ↓ |
| 2 doses of MEASLES VACCINE<br>Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE: _____/______/______ *M D Y*<br>Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: _____/______/______ *M D Y* | | OR | MEASLES Virus IgG Antibody test demonstrating immunity.<br>Copy of laboratory report must be attached. |
| 2 doses of MUMPS VACCINE<br>Dose 1 RECEIVED ≥ 12 MONTHS OF AGE: _____/______/______ *M D Y*<br>Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE: _____/______/______ *M D Y* | | OR | MUMPS Virus IgG Antibody test demonstrating immunity.<br>Copy of laboratory report must be attached. |
| 1 dose of RUBELLA VACCINE<br>Dose 1 RECEIVED ≥ 12 MONTHS OF AGE: _____/______/______ *M D Y* | | OR | RUBELLA Virus IgG Antibody test demonstrating immunity.<br>Copy of laboratory report must be attached. |

## 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)**

| | | | | |
|---|---|---|---|---|
| **3 doses of HEPATITIS B VACCINE**<br>Dose 1: _____/______/______ *M D Y*<br>Dose 2: _____/______/______ *M D Y*<br>Dose 3: _____/______/______ *M D Y* | OR | **3 doses of Combined HEPATITIS A & HEPATITIS B VACCINE**<br>Dose 1: _____/______/______ *M D Y*<br>Dose 2: _____/______/______ *M D Y*<br>Dose 3: _____/______/______ *M D Y* | OR | **LABORATORY PROOF OF DISEASE OR IMMUNITY TO HEPATITIS B**<br>Copy of laboratory report must be attached. |

rev June 2015

**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)**