



Saint Elizabeth  
University

PHYSICIAN ASSISTANT PROGRAM

## REQUIRED FORMS CHECKLIST

Please read and follow all instructions carefully for each form.

New Jersey State Law, Saint Elizabeth University and the SEU Physician Assistant Program requires documentation of immunizations and other medical requirements to be on file with both, the Office of Student Health Services and the SEU PA Program no later than August 1, 2025. **Non-Compliance will result in a \$350 fee and/or registration hold.**

Please complete all forms and upload to:

Office of Student Health Secure File Upload Portal

AND

PA Program External Verification through CastleBranch

### ☐ **REQUIRED FORM A - HEALTH FORM (6 pages)**

- Release of Medical and Immunization to SEU Office of Health Services – pg. 1

Note: This form authorizes your medical provider to release information to the Office of Health Services and should not be confused with Required form D listed below. Required form D authorizes the Office of Student Health Services to release your Immunization and TB Screenings to the Physician Assistant Program as required for Clinical Rotations.)

- Identification Data and Emergency Contacts – pg.2
- Health Insurance and Healthcare providers – pg.2
- Health History Questionnaire – pgs.3-4 (Must be completed by student; reviewed and signed by healthcare provider)
- Physical Examination - pg.5 (Must be completed and signed by healthcare provider)
- Healthcare Provider Attestation – pg.6 (Part A-completed by Student; Part B- completed by healthcare provider)

**Note(s): Physical Exam must be within six months of entrance**

### ☐ **REQUIRED FORM B - IMMUNIZATION RECORD**

- Form B: Required Vaccinations and Screenings (Must be completed and signed your physician or other healthcare provider)

### ☐ **REQUIRED FORM C - MENINGITIS INFORMATION SHEET**

- All students must confirm that they have received and read the Information about meningitis and the vaccine by signing the Meningitis Information Sheet (Form C).

### ☐ **REQUIRED FORM D**

Release of Immunization and TB screenings Physician Assistant Program. Note: This form authorizes the Office of Student health Services to release your Immunization and TB screenings to the Physician assistant Program as required for Clinical Rotations.

### ☐ **TECHNICAL STANDARDS**

- **Technical Standards Attestation** (Must be read and signed by student and healthcare provider)

### ☐ **Physician Forms and Guidelines for Requesting Medical Exemptions of Required Vaccines**

If you need a medical exemption for any of the required immunizations, please read and follow the instructions. Although the University may accept medical exemptions, Clinical Affiliates have the right to decline your exemption during the First Year Experience and during the clinical year.

## FORM B CHECKLIST

*You may be able to obtain acceptable immunization records from your current or previous healthcare provider, previous or current employers, high-schools, colleges, universities or other post-secondary institutions you may have attended or in your family records. Your immunization records must show exact vaccination dates (month, day, year) and must be signed by your physician or health care provider. **Note:** These immunization requirements are based on the CDC and the NJ State Law; clinical sites may have additional requirements. **Note:** Medical records are strictly confidential and are used exclusively by the Office of Student Health Services as required by Federal and State Law **Immunization records and TB screenings are an exception.** Your Immunization records and TB screenings will be made available to the SEU PA Program with your authorization as per Required Form D.*

### VACCINATIONS

- ☐ **MMR VACCINE:** 2 doses of MMR OR 2 measles, 2 mumps, 2 rubella
  - First dose must be after the 1<sup>st</sup> birthday
  - A minimum of 28 days is required between the two MMR doses (single dose vaccines are not available)
  - *Equivocal titers are considered negative*
  - **A copy of the lab report must also be submitted as evidence of MMR immunity.** (Must be within the last 5 years. Do not assume immunity based on previous lab results.)
- ☐ **HEPATITIS B VACCINE:** 3 dose series AND/OR A copy of the lab report as evidence of immunity
  - Minimum of 4 weeks *between doses 1 and 2*
  - Minimum of 8 weeks *between doses 2 and 3*
  - Minimum of 16 weeks *between doses 1 and 3*
- ☐ **TDAP (ONE DOSE) TDAP OR TD VACCINE:** Primary series completed (Must be within the last 10 yrs)
- ☐ **POLIO VACCINE:** Primary series completed OR Positive Titer
  - A copy of the lab report as evidence of immunity.
- ☐ **VARICELLA VACCINE:** 2 doses OR documented history of disease
  - A copy of the lab report must be submitted as evidence of immunity.
- ☐ **MENINGOCOCCAL VACCINE :** Required for students less than or equal to 23 years old and all on-campus residents
  - Serogroup ACWY (Final dose must be administered at or after the age of 16 years AND within 5 years of entry) OR SEROGROUP B AND Meningitis Information Form C. All students must confirm that they have received and read the Information about Meningitis and the vaccine by signing Form C, the Meningitis Information Sheet.
- ☐ **INFLUENZA VACCINE:** Annually
- ☐ **COVID-19 VACCINE + Booster** (As per CDC and ACIP)
- ☐ **IGRA-Interferon-gamma release assay or two step PPD /Mantoux testing** within six months of entry
  - Result must be in *mm of induration for the PPD*
  - A copy of the lab report must be submitted to demonstrate evidence of screening

**Immunization Information Line:** 973-290-4388; or [Immunization@steu.edu](mailto:Immunization@steu.edu)

- For additional assistance, contact Health Services at (973) 290-4132

## PSYCHOLOGICAL AND DISABILITY SERVICES

The health form that you and your physician complete will be accessible only to SEU Health Services staff due to state and federal privacy laws (HIPAA). They cannot be shared with other Saint Elizabeth University departments without proper permission as required by law.

If you require disability accommodations, **you must** self identify and provide appropriate documentation to the Office of Accessibility Services. Forms and additional information may be accessed here.

Saint Elizabeth University  
Accessibility Services  
Mahoney Library  
2 Convent Road  
Morristown, New Jersey 07960  
**Phone:** (973) 290-4261  
**accessibility@steu.edu**

If you have a mental health condition and/or take psychiatric medication and want Counseling Services to be aware of your history, **you must** self-identify. Service portals and additional information may be accessed here.

Saint Elizabeth University  
Office of Counseling Services  
Founders Hall  
2 Convent Road  
Morristown, New Jersey 07960  
**Phone:** (973) 290-4175

If you choose to sign release of information forms, these three service areas can coordinate your care. For further details or questions, please contact these individual offices.

## Required Form - A

### Authorization to Release Medical and Immunization Records to the Saint Elizabeth University Office of Student Health Services

(Note: This form authorizes your medical provider to release information to the SEU Office of Student Health Services and should not be confused with Required Form-D. Required Form-D authorizes the SEU Office of Student Health Services to release your Immunization and TB screenings to the SEU Physician Assistant Program as required for Clinical Rotations)

Date \_\_\_\_\_

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Student ID \_\_\_\_\_

I request and authorize (High School, College, Healthcare Provider, School Nurse)

to release (check all those that are indicated) ☐ Immunization Records ☐ Medical Records

to Health Services at Saint Elizabeth University. Please forward my records to:

Saint Elizabeth University  
Health Services – Founders Hall  
2 Convent Road  
Morristown, NJ 07960

If you wish, you may fax the information to (973) 290-4182.  
Questions/Concerns please call (973) 290-4132 or 4175.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_



# Saint Elizabeth University

PHYSICIAN ASSISTANT PROGRAM

## Required Form – A

### IDENTIFICATION DATA

Name \_\_\_\_\_  
Last /Maiden name First Middle Date of Birth (mm/dd/yyyy)

Home Address \_\_\_\_\_  
Street City State Zip Code

State/Country of Origin \_\_\_\_\_ Telephone \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_

First Semester Enrolled \_\_\_\_/\_\_\_\_ Expected Graduation Date \_\_\_\_/\_\_\_\_ Freshman \_\_\_\_ Transfer \_\_\_\_  
M/Y M/Y

CSE Leave Of Absence \_\_\_\_/\_\_\_\_ CSE Withdrawal \_\_\_\_/\_\_\_\_ CSE Dismissal \_\_\_\_/\_\_\_\_  
M/Y M/Y M/Y

### EMERGENCY INFORMATION – *contact to be notified in case of emergency*

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_ Tel.# \_\_\_\_\_  
Home work/cell

Please list another person who can be contacted in case the above person cannot be reached.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Tel.# \_\_\_\_\_

### HEALTH INSURANCE COVERAGE *Please include a copy of your present health insurance card front and back.*

Insurance Company Address Group and Policy#

Subscriber's Name Subscriber's DOB Subscriber's SS #

### HEALTHCARE PROVIDERS

*List the names, addresses and telephone numbers of Physicians, psychologists, or other health care providers you now consult.*

Name/specialty
Address
City, State
Telephone
Fax

Name/specialty
Address
City, State
Telephone
Fax

**Required Form A - Health History Questionnaire**

To be completed by student - reviewed and signed by physician/PA/NP

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

*Answer ALL questions Explain All YES Answers***ALLERGY**

	Yes	No
Any significant allergy to food, medications, insects, pollen?	<input type="checkbox"/>	<input type="checkbox"/>
List known allergies and type of reaction to them:		
Medication.....	<input type="checkbox"/>	<input type="checkbox"/>
Food.....	<input type="checkbox"/>	<input type="checkbox"/>
Environmental.....	<input type="checkbox"/>	<input type="checkbox"/>
Vaccines.....	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICATIONS:**

Do you take any medications regularly, including herbals, supplements and over the counter drugs? ☐ ☐

Medications: List all medications and dosage that you take regularly prescription and non-prescription (ex. Anxiety, ADD, depression, birth control, asthma, diabetes etc.)

**HOSPITALIZATION:**

Have you ever been admitted to a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any ER visits?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any severe injury?	<input type="checkbox"/>	<input type="checkbox"/>
List:		

**PAST ILLNESSES**

Hepatitis, mononucleosis, childhood diseases,	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Loss or absence of any body parts.	<input type="checkbox"/>	<input type="checkbox"/>
Severe/frequent colds or flu	<input type="checkbox"/>	<input type="checkbox"/>
Serious illness or injury	<input type="checkbox"/>	<input type="checkbox"/>

**ENT**

Any problems with your eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>
Loss of eye or eyesight	<input type="checkbox"/>	<input type="checkbox"/>

**CARDIOVASCULAR:**

Heart murmur/ palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots (not menstrual clots)	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged heart	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>

**RESPIRATORY: Yes No**

Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest infection (pneumonia)	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
How many? _____ How long? _____		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>

**SKIN**

Any problems with your skin?	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>

**ENDOCRINE**

Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

**URINARY**

Impaired function of any part of your urinary tract	<input type="checkbox"/>	<input type="checkbox"/>
Loss of a kidney	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent urinary infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>

**MENTAL HEALTH**

Any problems with your emotional health, requiring any form of therapy, including medications?	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever lie to anyone about your gambling?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone presently in your life hurt you or make you feel afraid?	<input type="checkbox"/>	<input type="checkbox"/>
History of depression?	<input type="checkbox"/>	<input type="checkbox"/>
History of self harm or harm to others?	<input type="checkbox"/>	<input type="checkbox"/>
History of abuse physically, emotionally or sexually?	<input type="checkbox"/>	<input type="checkbox"/>
Learning disabilities?	<input type="checkbox"/>	<input type="checkbox"/>

**DRUG AND ALCOHOL USAGE**

Have you ever felt you should cut down on your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have people annoyed you by criticizing your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>
Smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
Please give specific information about drug usage (ex. Marijuana, pain medication, ecstasy)		

**Required Form A - Health History Questionnaire**

To be completed by student - reviewed and signed by physician/PA/NP

Name: \_\_\_\_\_

**BLOOD:**

	Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Sickle-cell disease/trait	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>

**BONE AND JOINT**

Any serious disability, deformity or disease of bone, joint, or muscle?	<input type="checkbox"/>	<input type="checkbox"/>
Injury, neck, shoulder, back, knee, ankle, other	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

**NEUROLOGY**

Concussion/head injury	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>

**GASTROINTESTINAL**

Problems with any part of your intestinal tract or stomach?	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice/hepatitis/gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflex	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>

*Additional Explanations:***FAMILY HISTORY** completed by student

Check the following conditions which have appeared in your immediate family, indicating the person's relationship to you. (Ex. Father Cancer)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Sickle cell anemia / trait	<input type="checkbox"/> Learning disability
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Sudden death before age 50	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Cancer or Tumor	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease / Bladder Disease	<input type="checkbox"/> GYN Disorders
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Alcoholism / Drug Abuse	<input type="checkbox"/> Seizure
<input type="checkbox"/> Migraine		

Are your parents living? \_\_\_\_\_ # of brothers living \_\_\_\_\_ # of sisters living \_\_\_\_\_

If deceased, give relationship and cause of death and age of death \_\_\_\_\_

**To the Student:** I certify that the statements are true to the best of my knowledge.

Student Signature: \_\_\_\_\_ print name \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**History Reviewed by Physician/PA/NP-** Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**HEALTH AND NUTRITION**

	Yes	No
Are you following a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss / gain?	<input type="checkbox"/>	<input type="checkbox"/>

**REPRODUCTIVE SYSTEM (men):**

Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the scrotum or testicle	<input type="checkbox"/>	<input type="checkbox"/>
Undescended or absent testicle	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform testicular self-examination?	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>

**REPRODUCTIVE SYSTEM (women):**

Never had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
Any form of menstrual disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform breast self-exam?	<input type="checkbox"/>	<input type="checkbox"/>
Last menstrual period _____		
Abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
History of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>

**ACCIDENT PREVENTION**

Do you usually wear a seat belt when you ride in car?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear protective equipment when participating in a sports act?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink and drive?	<input type="checkbox"/>	<input type="checkbox"/>



## Required Form – A Physical Examination

Physical exam to be completed by the physician/PA/NP and performed  
*within six months prior to entrance* to the College

Patient Name \_\_\_\_\_ Sex M/F Date of Birth \_\_\_\_\_ **DATE OF EXAM** \_\_/\_\_/\_\_

Vision: *uncorrected* Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_; *with glasses/contacts* Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_

Hearing: normal ☐ Yes ☐ No Abnormal \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ Resp \_\_\_\_\_ Peak Flow (as indicated) \_\_\_\_\_

System	Satisfactory	Describe Abnormality
Eyes		
Ears		
Nose, throat		
Neck, thyroid		
Chest, lungs		
Breast		
Heart		
Abdomen, liver, kidneys, spleen		
Lymphatic's		
Hernia		
Genitalia		
Pelvic (if indicated)		
Rectal		
Extremities, back, spine		
Skin		
Joints		
Neurological		
Psychological		

**Laboratory Tests:** URINALYSIS \_\_\_\_\_

BLOOD Cholesterol (Fasting) \_\_\_\_\_ CBC \_\_\_\_\_ Sickie Trait Screening and EKG (for athletes) \_\_\_\_\_

Additional labs as indicated \_\_\_\_\_

Include copy of lab results, as needed

**Impression/Diagnosis/Plan: recommendations, continuing treatment, restriction, medications should be noted :** (attach as needed)

Applicant may participate in College activities: including sports, physical education and intramurals

☐ Without restriction

☐ With the following restrictions and reason: \_\_\_\_\_

***History Reviewed & Student Examined by:***

Physician name (print): \_\_\_\_\_ Date \_\_\_\_\_

Signature/stamp \_\_\_\_\_



## Required Form – A Healthcare Provider Attestation

### Part A: To be completed by Student

Name \_\_\_\_\_  
                     Last /Maiden Name                      First                      Middle                      Date of Birth (mm/dd/yyyy) \_\_\_\_\_

Home Address \_\_\_\_\_  
                                     Street                                      City                                      State                      Zip Code

State/Country of Origin \_\_\_\_\_ Telephone \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_

### Part B: To be completed by Physician

#### **Attestation:**

I have reviewed the immunization record, tuberculosis screening results, and Health History Questionnaire, and examined the above named student on (date)\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_. The student is in good health, is free from evidence of communicable disease and does not pose a health risk to students or employees at Saint Elizabeth University or to patients and employees of the clinical partners of the SEU PA Program.

<b>Healthcare Provider</b>	Address/Stamp
Print Name	
Signature	Phone
Date	Fax

**REQUIRED FORM - B**  
**IMMUNIZATION RECORD & TB SCREENINGS**



**Saint Elizabeth**  
**University**

PHYSICIAN ASSISTANT PROGRAM

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_ CLASS (YEAR): \_\_\_\_\_

**REQUIRED VACCINATIONS**

Vaccines	Dates Given	SEU and NJ State Requirements
MMR OR Measles Mumps Rubella	#1 ____/____/____ #2 ____/____/____ OR #1 ____/____/____ #2 ____/____/____ #1 ____/____/____ #2 ____/____/____ #1 ____/____/____ #2 ____/____/____	2 doses of MMR OR 2 measles, 2 mumps, 2 rubella First dose must be after the 1 <sup>st</sup> birthday  A minimum of 28 days is required between the two MMR doses (single dose vaccines are not available)
AND Measles  Mumps  Rubella	AND Positive Titer Date: ____/____/____ Required <u>copy of lab report</u> within <b>5 years</b>  AND Positive Titer Date ____/____/____ Required <u>copy of lab report</u> within <b>5 years</b>  AND Positive Titer Date: ____/____/____ Required <u>copy of lab report</u> within <b>5 years</b>	<i>Equivocal titers are considered negative</i>  <b>A copy of the lab report must be submitted as evidence of immunity.</b>
Hepatitis B	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____  AND/OR Positive Titer Date: ____/____/____ Required <u>copy of lab report</u>	3 dose series AND/OR <b>A copy of the lab report must be submitted as evidence of immunity.</b> Minimum of 4 weeks <i>between doses 1 and 2</i> Minimum of 8 weeks <i>between doses 2 and 3</i> Minimum of 16 weeks <i>between doses 1 and 3</i>
Tdap Td	<input type="checkbox"/> Tdap ____/____/____ <input type="checkbox"/> Td ____/____/____ <input type="checkbox"/> DTP <input type="checkbox"/> DT ____/____/____	Tdap (1 dose) Tdap or Td within 10 years Completed primary series
Polio	Primary series: <input type="checkbox"/> Oral <input type="checkbox"/> Injectable  Most recent booster : ____/____/____	Completed Primary series or Positive Titer
Varicella (Chicken Pox)	#1 ____/____/____ #2 ____/____/____  AND Positive Titer Date: ____/____/____  History of disease <input type="checkbox"/> No <input type="checkbox"/> Yes Date ____/____/____	2 doses varicella vaccine or history of disease and positive titer  Minimum of 4 weeks between doses if age 13 or older
Meningitis Serogroup ACWY  OR  Meningitis Serogroup B	1 ____/____/____ #2 ____/____/____ <input type="checkbox"/> Menomune <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo <input type="checkbox"/> Meningitis information sheet sign and submit  OR  #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero	This is a Requirement for students less than or equal to 23 years old and all on-campus residents. Final dose must be administered at or after the age of 16 years <b>AND</b> within 5 years of entry.  Required for students less than or equal to 23 years old

Signature Health Care Provider

(This form is invalid without the signature and or stamp of a healthcare provider)

Print Name

Date

Physician Assistant Program  
**REQUIRED FORM B – IMMUNIZATION RECORD & TB SCREENINGS**

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_

<b>Influenza</b>	____/____/____	Within one year of program start and annual update
<b>COVID19 Vaccine</b>	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson and Johnson <input type="checkbox"/> Other _____	As per CDC and ACIP
<b>Interferon-gamma release assay tests (IGRA) or 2 step PPD / Mantoux</b>	Interferon-gamma release assay tests (IGRA) ____/____/____ <input type="checkbox"/> pos. <input type="checkbox"/> neg. copy of report or 1) PPD ____/____/____ <input type="checkbox"/> Planted ____/____/____ <b>Read</b> ____/____/____ <b>result</b> ____mm 2) PPD ____/____/____ <input type="checkbox"/> Planted ____/____/____ <b>Read</b> ____/____/____ <b>result</b> ____mm  Positive PPD in past BCG history ____/____/____ If PPD or Interferon-gamma release assay tests (IGRA) is positive, chest x-ray is required: <b>chest x ray</b> ____/____/____ <input type="checkbox"/> normal <input type="checkbox"/> abnormal INH treatment began ____/____/____ completed ____/____/____	Result must be in <i>mm of induration for the PPD</i>  A copy of the lab report must be submitted to demonstrate evidence of immunity

**HEALTH CARE PROVIDER**

(This form is invalid without the signature and or stamp of a healthcare provider)

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

**UPLOAD TO:**

Office of Student Health Secure File Upload Portal  
AND  
PA Program External Verification through  
CastleBranch

**OR MAIL TO:**

Saint Elizabeth University  
**Office of Student Health Services**  
 Founders Hall  
 2 Convent Road,  
 Morristown, NJ 07960

**OR FAX TO:**

(973) 290-4182

**REQUIRED FORM - C**  
**MENINGITIS INFORMATION SHEET**  
**REQUIRED FOR ALL STUDENTS**



**Meningococcal Disease among College Students**

**(Read about meningitis and the vaccine on the VACCINE INFORMATION STATEMENT)**

In accordance with New Jersey State Law and Saint Elizabeth University, all university students must complete and return this form to the address below.

- 1) The university is to provide information about meningococcal meningitis, the disease, its severity, causes, disease prevention, treatment and the availability of the vaccine to prevent disease to all their students prior to matriculation (please see attached Meningococcal Disease Information Statement)
- 2) Meningitis Vaccine recommendations are as per *The Center for Disease Control (CDC)* and *The Advisory Committee on Immunization Practices (ACIP)*. Read this information on the Vaccine Information Statement, "Who should get Meningococcal vaccine and when."
- 3) The university is to document the student's receipt of the meningococcal information and their decision whether or not to receive a meningitis vaccine.

Students may go to their private physician or other healthcare provider for administration of the meningitis vaccine. Arrangements can be made with the Saint Elizabeth University Health Services for administration of the meningitis vaccine, if needed.

**Complete and Sign all indicated below:**

Yes ☐ No ☐ I have received information (What you need to know – Vaccine Information Statement) about meningitis, the vaccine, and its availability.

Yes ☐ No ☐ I have received the meningococcal (serogroup ACWY) vaccine. See Vaccine Information Statement as to "Meningococcal vaccines what you need to know".

Date #1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_

Yes ☐ No ☐ I have received the meningitis (serogroup B) vaccine. See Vaccine Information Statement as to "Serogroup B Meningococcal vaccine: what you need to know".

Date #1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_

Yes ☐ I have read the information regarding meningococcal meningitis disease. I understand the risks and benefits of immunization against meningococcal meningitis. I have decided at this time that I will NOT obtain the immunization against meningococcal meningitis disease. I understand that I may choose in the future to be immunized against meningococcal meningitis.

Name (please print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_  
(If student is under the age of 18 a parent's or guardian's signature is required)

This signature shall become part of the student's health record and is being required by New Jersey law, P.L. 2000c.25.

**Send this required form to:**

Saint Elizabeth University  
Health Services – Founders Hall  
2 Convent Road  
Morristown, NJ 07960

PHONE: (973) 290-4132, 4175 FAX: (973) 290-4182

**Any questions, please call Immunization Information Line: 973-290-4388**

## Required Form – D

### Authorization to release information to the SEU Physician Assistant Program

Name \_\_\_\_\_  
Last /Maiden Name First Middle Date of Birth (mm/dd/yyyy)

Home Address \_\_\_\_\_  
Street City State Zip Code

State/Country of Origin \_\_\_\_\_ Telephone \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_

By signing below, I am authorizing the release of my **immunization records** and **results of my tuberculosis screening** as documented in required Form B as well as the Healthcare Provider Attestation Statement (*Form A, page 5*) to the Physician Assistant Program in order to maintain a copy in my student record.

I am furthermore authorizing the Physician Assistant Program to release those records to all clinical sites to which I am assigned for my supervised clinical practice experiences.

I understand that **no other medical records** will be provided to Physician Assistant Program or the clinical site without my express authorization.

**Please forward a copy of my Immunization records, TB Screening and Healthcare provider Attestation forms records to:**

Saint Elizabeth University  
Physician Assistant program  
2 Convent Road  
Morristown, NJ 07960  
Attention: Kim Booth, Program Coordinator

Print Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Questions/Concerns please call (973) 290-4132 or 4175.

## TECHNICAL STANDARDS

---

These “technical standards” are required for admission and must be maintained throughout a student’s matriculation and progress through the SEU PA Program, and are required for graduation. It is expected that students be able to adhere to the technical standards throughout all aspects of the SEU PA Program including the classroom, small group, simulation, and clinical rotation courses and in all interactions with faculty, instructors, fellow students, preceptors, members of the healthcare team, patients and their families.

### Communication:

Applicants and students must be able to employ effective communication skills to participate in the meaningful exchange of information in oral, written and electronic formats in the English language. Therefore, they must be able to speak clearly and intelligibly, hear sufficiently, successfully elicit and accurately share information with instructors, classmates, patients and their families, and members of the healthcare team. In addition, applicants and students must be able to recognize and appropriately respond to verbal, visual, behavioral, and other non-verbal cues.

### Observation:

Applicants and students must be able to observe material presented in a variety of learning modalities throughout all phases of instruction including during the clinical care of patients. Therefore, they must have the visual acuity to read information presented in print and electronic formats; be able to observe classroom presentations, laboratory and lecture demonstrations, on-line modules, simulation activities and clinical experiences; and be able to observe patients accurately at a distance, and close at hand, with or without standard medical equipment to determine findings on a physical examination.

### Sensory / Motor Function:

Applicants and students must have the sensory and motor skills necessary to fully participate in all aspects of the educational program and patient care. Therefore, they must have sufficient visual, hearing, smell and somatic capacity to fully appreciate the nuances of the educational experiences in all settings including but not limited to the classroom, laboratory and patient care settings. Applicants and students must have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic techniques. They should be able to execute movements reasonably required to move from area to area, maneuvering small spaces, calibrate and use large and small equipment, position and move patients, and provide patients with general care and emergency treatment.



### **Critical Thinking Skills:**

Applicants and students must have critical thinking skills to acquire knowledge and integrate that knowledge into the practical care of the patient. Therefore, they must have the intellectual capacity to measure, calculate, reason, analyze, integrate, and synthesize information from various sources. In addition, applicants and students must have the critical thinking skills necessary to problem solve in a clinical setting, perform multiple tasks simultaneously, discriminate normal from abnormal findings during the patient encounter and work-up, and incorporate that information along with the information from peers, instructors and the medical literature into the formulation of diagnosis and treatment plans.

### **Professional Attributes:**

Applicants and students must exhibit professional and ethical behaviors at all times and possess the emotional health required for full participation in the educational program. Therefore, they must demonstrate the emotional stability and maturity to be able to exercise good judgment during all aspects of the program and in the care of patients; and demonstrate honesty, integrity, dedication, compassion, nondiscrimination and motivation in all interactions. In addition, students and applicants should have the ability to adapt to changing environments, display flexibility, and learn to function in an environment of uncertainty inherent in the clinical practice of medicine.

### **Technical Standards Notes:**

Applicants to the SEU PA Program do not need to disclose information about reasonable accommodation needs prior to an admission decision. Applicants accepted for admission to the SEU PA Program are required to verify that they understand and meet these technical standards prior to matriculation. Admission decisions are made on the assumption that each candidate can meet technical standards without consideration of disability.

An offer for admission can be withdrawn if it becomes apparent that the applicant/student is unable to perform any of the essential functions or meet any of the technical standards.

It should also be noted that successful completion of all clinical rotation courses is a graduation requirement, and some facilities with which the SEU PA Program affiliates may not be able to meet the same accommodations as those offered to the student by the University during the didactic portion of the curriculum.

The Office of Accessibility Services at Saint Elizabeth University provides assistance and accommodations for all students with documented physical, medical, learning, emotional and/or psychological disabilities, both temporary and permanent:

<https://www.steu.edu/academics/accessibility-services/>



## Appendix A

### SEU Physician Assistant Program Technical Standards Attestation

---

#### **Part A: To be completed by Student**

I have read and understand the Technical Standards for the SEU Physician Assistant Program. I acknowledge my understanding and, to the best of my knowledge, agree that I meet these standards, with or without reasonable accommodations. I also understand that should I need an accommodation(s) due to disability or should the need arise during my studies, it is my responsibility to contact the Office of Accessibility Services to determine if any specific accommodations may be necessary and can be made.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### **Part B: To be completed by Physician**

##### **Attestation:**

I have reviewed the Technical Standards for the SEU Physician Assistant Program, and can confirm, to the best of my knowledge, the above named student meets these standards, with or without reasonable accommodations and can perform all skills required by the Saint Elizabeth University PA Program. Additionally this student can participate in the clinical rotations of clinical partners to the SEU PA Program.

<b>Healthcare Provider</b>	Address/Stamp
Print Name	
Signature	Phone
Date	Fax

This form must be submitted to the SEU PA Program office prior to matriculation.



## Vaccine Preventable Disease Program

### GUIDANCE FOR REQUESTING A MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

The Department of Health, Vaccine Preventable Disease Program, received inquiries seeking guidance on obtaining medical exemptions from mandatory immunizations for children attending schools, preschools, and child care facilities in New Jersey. Specifically, the Department received questions on what should be included in the medical exemption documentation to ensure that it meets the requirements for the exemptions. In response, the Department is issuing this guidance document to assist healthcare providers, schools, preschools, child care facilities, and local health departments with medical exemptions for mandatory vaccines.

By way of background, N.J.A.C. 8:57 – 4.2 states that a “principal, director or other person in charge of a school, preschool, or child care facility shall not knowingly admit or retain any child whose parents or guardian has not submitted acceptable evidence of the child’s immunization,” according to the schedules specified in the rules. However, an unvaccinated child may attend a school, preschool, or child care facility if the required vaccination is medically contraindicated for the child. See N.J.A.C. 8:57-4.3. In order to obtain a medical exemption, N.J.A.C. 8:57-4.3 requires a written statement to be submitted to the school, preschool, or child care center by a physician licensed to practice medicine or osteopathy, or an advanced practice nurse who is licensed in any jurisdiction in the United States indicating that the immunization is medically contraindicated for the child for a specific period of time, and the reason(s) for the medical contraindication, based upon valid reasons as enumerated by the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service or the American Academy of Pediatrics (AAP) guidelines.

These guidelines are accessible on the CDC and AAP website at <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html> or <https://redbook.solutions.aap.org/redbook.aspx>.

To assist treating healthcare providers with submitting adequate and sufficient medical exemption requests that meet the requirements of N.J.A.C. 8:57-4.3, and to guide school, preschools, child care facilities, and local health departments with determining whether an exemption is consistent with the rule requirements, the Department drafted the attached *Request for Medical Exemption from Mandatory Immunization* form that may be used for medical exemptions. Table 1. of the form lists the vaccines that are mandated for children to attend schools, preschools, and child care facilities and current ACIP contraindications and precautions for each vaccine. This form allows the healthcare provider to indicate the vaccine for which the exemption is sought as well as the ACIP contraindication or precaution that is recognized for that specific vaccine and applies to the child. In the event the form does not list the specific contraindication or precaution that exempts the child from a particular vaccine, the form also includes a space marked as “Other” where the healthcare provider may explain, in detail, the contraindication or precaution for the child’s receipt of vaccine. The use of “Other” as a contraindication or precaution should be extremely rare, and the contraindication/precaution must be consistent with ACIP guidelines and established national standards for vaccination practices to be accepted. Table 2. of the form lists conditions that are **incorrectly** perceived as contraindications or precautions for vaccines, which provides further guidance to the healthcare provider in determining whether the exemption is valid and medically accepted.

The form will also assist schools, preschools, child care facilities, and local health departments in determining the validity of the exemption and whether it should be accepted or rejected. Specifically, the school, preschool, child care facility, and local health department may accept a medical exemption in which a healthcare provider indicates a contraindication or precaution listed in Table 1. However, a school, preschool, child care facility, and local health department should not accept a medical exemption in which a healthcare provider indicates a condition listed in Table 2.

It should be noted that healthcare providers who submit medical exemptions for mandatory vaccinations must ensure that the information submitted is accurate and verifiable. Supporting medical documentation may be requested by the school, preschool, or child care facility and/or by local or state public health authorities. Healthcare providers who misrepresent medical information may be referred to the New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

If a healthcare provider, school, preschool, or child care facility has questions about medical exemptions, it should direct the questions to the local health department with jurisdiction over the municipality in which the school is located. To locate the local health department, please visit the New Jersey Department of Health website at <https://www.nj.gov/health/lh/community/index.shtml#1>. Local health departments with questions can directly contact the Vaccine Preventable Disease Program at 609-826-4861.

Please also note that the use of the Form is not a mandate or requirement, but rather a tool that may be used by healthcare providers, schools, preschools, child care facilities, and local health departments in determining the validity of a medical exemption from a mandatory immunization.

### INSTRUCTIONS FOR COMPLETION

It is easiest to use the latest version of Adobe Reader DC. If you do not have the latest version, download and install the free software by visiting this webpage: <https://get.adobe.com/reader/>

1. Fill out the form completely. ALL form fields are required except where noted as being optional.
  - a. Enter the name of the Student and other identifying information.
  - b. Check off each vaccine for which an exemption is requested.
    - i. For each vaccine for which an exemption is requested, check to indicate whether the exemption is Temporary (indicate the date through which the exemption is valid) or Permanent.
    - ii. Check the ACIP contraindication/precaution applicable for each vaccine for which an exemption is requested.
  - c. If the contraindication/precaution is not included in Table 1, please put an "X" next to "Other" and fully explain. Please be sure that the contraindication/precaution does not appear in Table 2, that there is a valid contraindication/precaution noted for each vaccine for which an exemption is requested, and that the contraindication/precaution is consistent with ACIP/AAP guidelines and established national standards for vaccination practices.
2. Sign and date the Attestation Statement
3. Provide a copy to the person requesting the medical exemption or directly to the school, preschool or child care center.
4. Keep a copy of the form for your records.

# REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

Name of Student: <small>first / middle / last</small>	Date of Birth:
Name of Parent/Guardian (if under 18): <small>first / middle / last</small>	Primary Phone:
Patient/Parent Home Address: <small>address 1</small> <small>address 2</small> <small>city</small> <small>state</small> <small>zip</small>	
Patient/Parent Email Address:	

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), available at <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html> or <https://redbook.solutions.aap.org/redbook.aspx>

Please check the website to ensure that you are reviewing the most recent ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

Table 1. ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
<input type="checkbox"/> DTaP, Tdap	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</li> <li><input type="checkbox"/> Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of DTP, DTaP, or Tdap</li> </ul> <p><b>Precautions</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP or Tdap until neurologic status clarified and stabilized</li> <li><input type="checkbox"/> Guillain-Barré syndrome &lt; 6 weeks after previous dose of tetanus-toxoid-containing vaccine</li> <li><input type="checkbox"/> History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus toxoid-containing vaccine</li> </ul>
<input type="checkbox"/> DT, Td	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</li> </ul> <p><b>Precautions</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Guillain-Barré syndrome &lt; 6 weeks after a previous dose of tetanus-toxoid-containing vaccine.</li> <li><input type="checkbox"/> History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria- or tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine</li> </ul>

**New Jersey Department of Health  
Vaccine Preventable Disease Program**

**REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION**

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
<input type="checkbox"/> <b>Haemophilus influenzae type b (Hib)</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
<input type="checkbox"/> <b>Hepatitis B (HepB)</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Hypersensitivity to yeast
<input type="checkbox"/> <b>Inactivated poliovirus vaccine (IPV)</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component  <b>Precautions</b> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> <b>Influenza, inactivated injectable (IIV)</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component  <b>Precautions</b> <input type="checkbox"/> Guillain-Barré syndrome < 6 weeks after a previous dose of influenza vaccine <input type="checkbox"/> Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, or recurrent emesis; or required epinephrine or another emergency medical intervention (IIV may be administered in an inpatient or outpatient medical setting, under the supervision of a healthcare provider who is able to recognize and manage severe allergic conditions)
<input type="checkbox"/> <b>Influenza, recombinant (RIV)</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine  <b>Precautions</b> <input type="checkbox"/> Guillain-Barré syndrome < 6 weeks after a previous dose of influenza vaccine



**New Jersey Department of Health  
Vaccine Preventable Disease Program**

**REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION**

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
<input type="checkbox"/> <b>MMR</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <p><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with human immunodeficiency virus [HIV] infection who are severely immunocompromised)</p> <p><input type="checkbox"/> Family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test</p> <p><b>Precautions</b></p> <p><input type="checkbox"/> Recent (<math>\leq 11</math> months) receipt of antibody-containing blood product (specific interval depends on product)</p> <p><input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura</p> <p><input type="checkbox"/> Need for tuberculin skin testing or interferon gamma release assay (IGRA) testing</p>
<input type="checkbox"/> <b>Meningococcal (MenACWY)</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <p><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</p>
<input type="checkbox"/> <b>Meningococcal (MenB)</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <p><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</p> <p><b>Precautions</b></p> <p><input type="checkbox"/> Pregnancy</p>
<input type="checkbox"/> <b>Pneumococcal (PCV13)</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <p><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid-containing vaccine or to a component of a vaccine (PCV13 or any diphtheria-toxoid-containing vaccine), including yeast</p>

**New Jersey Department of Health  
Vaccine Preventable Disease Program**

**REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION**

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
<input type="checkbox"/> <b>Varicella</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<div style="background-color: #f0f0f0; padding: 2px; margin-bottom: 10px;"><b>Contraindications</b></div> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or persons with HIV infection who are severely immunocompromised) <input type="checkbox"/> Pregnancy <input type="checkbox"/> Family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test <div style="background-color: #f0f0f0; padding: 2px; margin-top: 10px;"><b>Precautions</b></div> <input type="checkbox"/> Recent ( $\leq 11$ months) receipt of antibody-containing blood product (specific interval depends on product) <input type="checkbox"/> Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; avoid use of these antiviral drugs for 14 days after vaccination <input type="checkbox"/> Use of aspirin or aspirin-containing products
<input type="checkbox"/> Other. Please explain fully and attach additional sheets as necessary. Please be sure to check Table 2 below to ensure that the condition is not one incorrectly perceived as a contraindication or precaution.		

**Attestation**

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation. I also understand that any misrepresentation might result in referral to the New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

Healthcare Provider Name (please print): \_\_\_\_\_ Specialty: \_\_\_\_\_

NPI Number: \_\_\_\_\_ License Number: \_\_\_\_\_ State of Licensure: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**New Jersey Department of Health  
Vaccine Preventable Disease Program**

**REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION**

**Table 2. Examples of Conditions incorrectly perceived as contraindications or precautions to vaccination\*  
(i.e., vaccines may be given under these conditions)**

<b>Vaccine</b>	<b>Conditions incorrectly perceived as contraindications and precautions to vaccines (i.e., vaccines may be given under these conditions)</b>
<b>General for MMR, Hib, HepB, Varicella, PCV13, MenACWY</b>	<ul style="list-style-type: none"> <li>• History of Guillain-Barré syndrome</li> <li>• Recent exposure to an infectious disease</li> <li>• History of penicillin allergy, other nonvaccine allergies, relatives with allergies, or receiving allergen extract immunotherapy</li> </ul>
<b>DTaP</b>	<ul style="list-style-type: none"> <li>• Fever within 48 hours after vaccination with a previous dose of DTP or DTaP</li> <li>• Collapse or shock like state (i.e., hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP</li> <li>• Seizure ≤ 3 days after receiving a previous dose of DTP/DTaP</li> <li>• Persistent, inconsolable crying lasting ≥ 3 hours within 48 hours after receiving a previous dose of DTP/DTaP</li> <li>• Family history of seizures</li> <li>• Family history of sudden infant death syndrome</li> <li>• Family history of an adverse event after DTP/DTaP</li> <li>• Stable neurologic conditions (e.g., cerebral palsy, well-controlled seizures, or developmental delay)</li> </ul>
<b>Hepatitis B (HepB)</b>	<ul style="list-style-type: none"> <li>• Pregnancy</li> <li>• Autoimmune disease (e.g., systemic lupus erythematosus or rheumatoid arthritis)</li> </ul>
<b>Influenza, inactivated injectable (IIV)</b>	<ul style="list-style-type: none"> <li>• Nonsevere (e.g., contact) allergy to latex, thimerosal, or egg</li> </ul>
<b>MMR</b>	<ul style="list-style-type: none"> <li>• Breastfeeding</li> <li>• Pregnancy of recipient's mother or other close or household contact</li> <li>• Recipient is female of child-bearing age</li> <li>• Immunodeficient family member or household contact</li> <li>• Asymptomatic or mildly symptomatic HIV infection</li> <li>• Allergy to eggs</li> </ul>
<b>Tdap</b>	<ul style="list-style-type: none"> <li>• History of fever of ≥ 40.5° C (≥ 105° F) for &lt; 48 hours after vaccination with previous dose of DTP/DTaP</li> <li>• History of collapse or shock-like state (hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP</li> <li>• History of persistent, inconsolable crying lasting &gt; 3 hours within 48 hours of receiving a previous dose of DTP/DTaP</li> <li>• History of extensive limb swelling after DTP/DTaP/Td that is not an Arthus-type reaction</li> <li>• History of stable neurologic disorder</li> <li>• Immunosuppression</li> </ul>
<b>Varicella</b>	<ul style="list-style-type: none"> <li>• Pregnancy of recipient's mother or other close or household contact</li> <li>• Immunodeficient family member or household contact</li> <li>• Asymptomatic or mildly symptomatic HIV infection</li> <li>• Humoral immunodeficiency (e.g., agammaglobulinemia)</li> </ul>

\* For a complete list of conditions, please review the ACIP Guide to Contraindications and Precautions accessible at <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html>.