



NJCU HEALTH AND WELLNESS CENTER

2039 Kennedy Blvd., Jersey City, NJ 07305-1597
Vodra Hall, Suite 107
(201) 200-3456 or 3457 ♦ Fax: (201) 200-2011

ENTRANCE HEALTH RECORD

DIRECTIONS: The Entrance Health Record is to be completed by the student and returned to the Health and Wellness Center at the above address. All medical information is confidential and will not be released without the student's written permission with the exception of vital information in case of a medical emergency. Parent or guardian's signature is required if the student is under the age of 18. INCOMPLETE FORMS ARE NOT ACCEPTED.

Undergraduate Graduate Re-Admit Certification Transfer Other _____
(Please Specify)

PLEASE PRINT

Name: Last _____ First: _____ M.I. _____

Maiden/Former Name: _____ SSN or Student ID # _____ Date of Birth ___/___/___ Sex ___

Address _____
(Permanent Home) Street City or Town State Zip

Address _____
(Local, if different from above) Street City or Town State Zip

Phone (Home) _____ Work _____ Local _____ Cell _____

PERSONS TO NOTIFY IN CASE OF EMERGENCY (Please complete both):

1. Name _____ Relationship _____ Phone _____
Additional Phone # _____ or Cell Phone # _____

2. Name _____ Relationship _____ Phone _____
Additional Phone # _____ or Cell Phone # _____

HEALTH & HOSPITALIZATION INSURANCE:

Name of health and hospitalization insurance company _____

Name of Insured _____ Policy Number _____
(Information regarding the purchase of optional student health insurance is available at the Health and Wellness Center, Vodra 107)

MOST RECENT HEALTHCARE PROVIDER: (Name) _____

Address: _____ Phone # _____

MEDICAL CONSENT AND RELEASE:

Permission is hereby given to perform routine health examination, provide preventative measures, medical treatment and first aid at the Health and Wellness Center of New Jersey City University and to make necessary referrals. I also consent to the release of my University medical records to appropriate health care providers in the event of an emergency.

Date: _____ Signature: _____

Signature of Parent /Guardian: _____ Relationship: _____
(If student is under 18 years of age)

PERSONAL HISTORY (PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING)

Use the space below to provide additional details

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glasses/Contact Lens | <input type="checkbox"/> Recent weight gain or loss
how much _____ ? |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcohol or Substance Abuse | <input type="checkbox"/> Hearing/Speech Deficit | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Murmur/Heart Problem | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Smoker _____ Pks/day? |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tonsillitis (Chronic) |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> High Blood Pressure/ Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Convulsions/Seizures/Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcer/Chronic Gastritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Unexplained Aches & Pains |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | _____ |
| <input type="checkbox"/> Environmental/Seasonal Allergies | <input type="checkbox"/> Meningitis | _____ |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Migraines/ Frequent Headaches | _____ |

If you have checked any of the above, please explain fully:

Allergies to medications or foods: _____

Current medications: _____

Hospitalizations and surgeries: _____

Serious injuries: _____

FAMILY HISTORY (please check and complete)

Family	Living Please indicate age	State of Health Please indicate here if any family member has Diabetes, Cancer, Heart Disease, High Blood Pressure, Kidney Problems, or OTHER	Deceased (Please indicate age and cause of death)
Mother			
Father			
Siblings			

I hereby certify that the information submitted on this health record is complete and correct.

Signature of Student

Date

NEW JERSEY STATE IMMUNIZATION REQUIREMENTS

New Jersey Law requires all students to submit documentation of immunity to measles, mumps, and rubella prior to registration. **Students who do not provide this information will be blocked from future registrations.**

REQUIRED ► Measles (Rubeola)- **TWO doses** of live vaccine given on or after the first birthday (and after 1968.)
The second dose at least one month after the first.

REQUIRED ► Mumps - One dose of the vaccine given after 1968, and on or after the first birthday.

REQUIRED ► Rubella (German Measles) – **One dose** of the vaccine given after 1968, and on or after the first birthday.

REQUIRED ► Meningitis * - One dose of the vaccine is **MANDATORY** for **NEW students living in University Residence Halls** – *The vaccine remains optional for all other students at the current time.*

***This section must be completed and signed by a physician or health care provider
OR a copy of your immunization records must be attached***

REQUIRED IMMUNIZATIONS

Student Name (PRINT NAME) _____

Student ID # or SSN : _____ Date of Birth : ____/____/____

MMR (Combined Measles, Mumps, Rubella Vaccine) Month /Day /Year **MMR # 1** ____/____/____ **MMR # 2** ____/____/____

Measles (Single Antigen Measles Vaccine) Month /Day /Year ____/____/____

Mumps (Single Antigen Mumps Vaccine) Month /Day /Year ____/____/____

Rubella (Single Antigen Rubella Vaccine) Month /Day /Year ____/____/____

TITER RESULTS FOR MEASLES, MUMPS, RUBELLA MUST BE ACCOMPANIED BY A COPY OF THE LABORATORY REPORT

* **Meningitis** (Adult Meningococcal Meningitis Vaccine – 1 dose) ____/____/____ Menomune™ or Menactra™ - Please circle
*** Required by NJ law for NEW students living in University Residence Halls**

RECOMMENDED IMMUNIZATIONS - (Optional at the present time)

Meningitis ____/____/____ Menomune™ or Menactra™ - Please circle

This vaccine is **MANDATORY** for **NEW students living in University Housing**. It is optional for all other students at the current time.

Hepatitis B Vaccine : Series of 3 doses #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

Tetanus/Diphtheria: (within the last 5 years) ____/____/____ **Varicella**: (Chicken Pox) ____/____/____

Mantoux (TB testing) Date of test ____/____/____ Result _____mm. Chest X-Ray: _____ Result: _____

FORMS WITHOUT SIGNATURES AND THE REQUIRED INFORMATION WILL BE CONSIDERED INCOMPLETE

Signature of Health Care Provider _____ **Print Name** _____

Address: _____ **Ph #** _____ **Fax#** _____

Office Stamp: _____ **Date**: _____

EXEMPTIONS

(If you are applying for an EXEMPTION, please check below and provide the information indicated.)

- Immune Status** - Measles, Mumps and Rubella antibody titers (Blood Test) Copy of laboratory results showing that you are immune is required. Only positive or immune titers will be accepted. Equivocal results are NOT acceptable.
- Age** - Born prior to January 1, 1957 (valid for MMR exemption only)
- Medical** - Physician statement required – must include diagnosis. If pregnant, statement must include your due date. (This exemption is reviewed to determine continuation of exemption.) You may be required to submit a physician statement annually.
- Religious** – Statement explaining how these immunizations conflict with your religious beliefs is required.

Where can you obtain an acceptable record of your immunizations? Students are responsible for contacting the various agencies or institutions and requesting a copy of their immunization records. **All records MUST be in English or accompanied by a translation.**

- **High School or previous Colleges** – A copy of the immunization record may be obtained from your high school, Board of Education, or a previously attended college. These records may contain adequate information.
- **Personal Immunization Record** – Records from pediatricians or family medical providers are acceptable, if verified (with stamp or signature), and contain proof of minimum requirements.
- **Local Health Department** – If primary immunizations were received at a local health department, a copy may be obtained from this source.

MENINGITIS INFORMATION

By State Law, every incoming student must be provided with information about MENINGITIS and the availability of a vaccine to prevent Bacterial Meningitis. **All incoming students (including re-admits) must complete and return the survey below.**

All NEW students (residing in on-campus housing) are required to show proof of one Meningitis Vaccination.

- **Definition:** Meningitis is an inflammation of the linings of the brain and spinal cord caused by either viruses or bacteria.
- **Viral meningitis** is more common than bacterial meningitis and usually occurs in late spring and early summer. Signs and symptoms of viral meningitis may include stiff neck, headache, nausea, vomiting, and rash.
- **Bacterial meningitis** occurs rarely and sporadically throughout the year, although outbreaks tend to occur in late winter and early spring. Bacterial meningitis in college-aged students is most likely caused by *Neisseria meningitidis* or *Streptococcus pneumoniae*. Common early symptoms include fever, severe sudden headache accompanied by mental changes, neck stiffness, and rash. Because meningococcal meningitis can cause grave illness and rapidly progress to death, it requires early diagnosis and treatment. In contrast to viral meningitis, persons who have had intimate contact with a case will require prophylactic therapy. Untreated meningococcal disease can be fatal.
- **Incidence:** About 2,600 people get meningococcal disease each year in the U.S. 10-15% of these people die, in spite of treatment with antibiotics.
- **Prevention:** Meningococcal vaccine can prevent 2 of the 3 types of meningococcal disease in older children and adults. **The American College Health Association now recommends vaccination for all college-age students, (particularly those who live in dormitories).**
- **CONTACT YOUR HEALTH CARE PROVIDER FOR ADDITIONAL VACCINE INFORMATION.**

MENINGITIS SURVEY – REQUIRED

This survey shall become part of the student's health record and is being required by N.J. Law, P.L. 2000 c.25.

Student Name (PRINT) _____ SSN or Student ID # _____

I have read the above information about Meningitis, the effectiveness of the vaccine, and the availability of a meningitis vaccine.

Check one below:

- a. _____ I have decided to receive the meningitis vaccine now or at some future time.
- b. _____ I have decided not to receive the meningitis vaccine.
- c. _____ I am undecided about whether or not to receive the meningitis vaccine.
- d. _____ I have received the meningitis vaccine on ____/____/____/ (Menomune™ or Menactra™) – Please circle

Administered by: _____ (Signature of Health Care Provider).

Signature _____ Date _____
(Student or Parent/Guardian if student is under 18 years of age).