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
Email: HWC@NJCU.EDU

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. **DO NOT send the form to the Admissions Office**. All medical / immunization 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**

PLEASE CHECK: ☐ Undergraduate ☐ Graduate ☐ Re-Admit ☐ Certification ☐ Transfer ☐ Other _____

Starting Semester: ☐ Fall ☐ Spring ☐ Summer YEAR: _____ Do you plan to live on campus? ☐ Yes ☐ No

PLEASE PRINT ALL INFORMATION, EXCEPT WHERE A SIGNATURE IS REQUIRED – PLEASE USE INK

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

NJCU Student ID # (if known) or

Maiden/Former Name: _____ Last **4** digits of SSN # _____ Date of Birth ____/____/_____ Gender _____

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

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

Phone (Cell) _____ Home _____ Work _____

Email: _____

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

1. Name_____Relationship_____ Phone _____

Cell Phone # _____ Work Phone # _____

2. Name_____Relationship_____Phone_____

Cell Phone # _____ Work Phone # _____

HEALTH & HOSPITALIZATION INSURANCE: ***Do you have health insurance*?** ☐ **YES** ☐ **NO** If yes, please indicate the company name and policy number of the insurance: _____

_____

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:_____
(If student is under 18 years of age, parent or legal guardian must sign here)

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

Use the space below to provide additional details

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

_____

_____

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

_____

_____

_____

ALLERGIES: ***(to medications or foods):***

_____

_____

Current medications: (please include prescription contraceptives) and over the counter medications used on a frequent basis:

_____

_____

_____

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	**If family member is deceased** (Please indicate age of death 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 fully comply with immunization regulations.
Students who fail to comply will be blocked from second semester registration and excluded from University housing.

STUDENT NAME (PRINT NAME) _____

NJCU Student ID # or last 4 digits of SSN: _____ **Date of Birth:** _____/_____/_____

REQUIRED IMMUNIZATIONS FOR ALL STUDENTS

MEASLES, MUMPS, RUBELLA (MMR) (Students born BEFORE January 1, 1957 are exempt from the MMR requirement).
Measles: 2 doses of live vaccine Mumps and Rubella: 1 dose of each. All doses MMR given after 1968, and on or after the first birthday.

MMR *(Combined Measles, Mumps, Rubella Vaccine)* Month /Day /Year **MMR # 1** _____/_____/_____ **MMR # 2** _____/_____/_____
(Must be at least 28 days from #1)

Measles *(Single Antigen Measles Vaccine)* Month /Day /Year **#1** _____/_____/_____ **#2** _____/_____/_____

Mumps *(Single Antigen Mumps Vaccine)* Month /Day /Year **#1** _____/_____/_____ **#2** _____/_____/_____

Rubella *(Single Antigen Rubella Vaccine)* Month /Day /Year **#1** _____/_____/_____ **#2** _____/_____/_____

OR

LABORATORY PROOF OF IMMUNITY: Measles, Mumps, Rubella Virus IgG Antibody test demonstrating immunity. Copy of the **official laboratory report** must be attached.

HEPATITIS B **(Required for all students registering for 12 credits or more) 3 Dose Series**

Dose #1 _____/_____/_____ **Dose #2** _____/_____/_____ **Dose #3** _____/_____/_____

OR

LABORATORY PROOF OF IMMUNITY: Hepatitis B Surface Antibody test demonstrating immunity. Copy of the **official laboratory report** must be attached.

***MENINGITIS B or MEN B - Trumenba (3 doses) or Bexsero (2 doses)**

MENINGITIS B: Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose # 3_____/_____/_____ Name of vaccine _____

REQUIRED FOR ALL STUDENTS APPLYING FOR NJCU HOUSING

***MENINGOCOCCAL MENINGITIS A,C,Y,W-135 (Menactra/Menveo- given within the last 5 years and after age 16)**

1st dose _____/_____/_____ Most recent dose _____/_____/_____

RECOMMENDED IMMUNIZATIONS - *(Optional at the present time)*

VARICELLA (Chickenpox): Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

TETANUS, DIPTHERIA, PERTUSSIS (Tdap): 1 Dose within the last 10 years _____/_____/_____

HEPATITIS A: Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

MANTOUX TEST _____/_____/_____ **Result** _____**mm** **Chest x-ray/QuantiFERON Gold/T-Spot Blood test** _____/_____/_____
(attach radiology/laboratory test results)

FORMS WITHOUT SIGNATURE or OFFICE STAMP AND THE REQUIRED INFORMATION WILL BE CONSIDERED INCOMPLETE

Signature of Health Care Provider _____ Print Name _____

Address: _____ Ph # _____ Fax# _____

Office Stamp: _____ Date: _____

Students may attach a copy of their official immunization record

IMMUNIZATION EXEMPTIONS

(If you are applying for an EXEMPTION, *please check below, and you* ***MUST*** *provide the information required for the exemption*)

☐ **Immune Status Exemption** – **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 Exemption** - Born prior to January 1, 1957 **(valid for MMR immunization exemption only)** – There is **NO AGE exemption** for the **Hepatitis B** immunization

☐ **Medical Exemption**- Physician statement **REQUIRED** – must include diagnosis. Diagnosis must be an acceptable diagnosis as determined by our office and *based on national guidelines*. **If pregnant**, your physician statement must include your due date. You will be exempted until 6 weeks after your due date. **Please note that breast-feeding an infant does NOT constitute a medical exemption as per national immunization guidelines.** Medical exemptions will be reviewed annually and you may be required to submit a physician statement annually.

☐ **Religious Exemption** – Statement explaining **HOW these immunizations conflict with your religious beliefs is required**. You do not need to name your religion, and the statement **MUST be written by the student**, not by the clergy or a copy of state regulations. The State of New Jersey does not recognize or accept philosophical objections.

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) _____ Last **4** digits of SSN # **or NJCU 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. NOTE: This vaccine is REQUIRED to live in Campus Housing

c. _____ I am undecided about whether or not to receive the meningitis vaccine.

d. _____ I have **received the meningitis vaccine** on _____/_____/_____/ *Name of Vaccine:*_____

Administered by: _____ **(Signature of Health Care Provider)** Date: _____

(Student or Parent/Guardian if student is under 18 years of age)

Signature of Student _____ Date _____