



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**
Students who fail to comply will be blocked from second semester registration and excluded from University housing

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

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

Hospitalizations and surgeries: _____

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

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

REQUIRED ► MUMPS - ONE dose of the vaccine given after 1968, and on or after the first birthday. Two doses preferred.

REQUIRED ► RUBELLA (German Measles) - ONE dose of the vaccine given after 1968, and on or after the first birthday.
 Two doses preferred.

REQUIRED ► HEPATITIS B - **THREE** doses - **FOR ALL STUDENTS REGISTERING FOR 12 OR MORE CREDITS** -

REQUIRED ► MENINGITIS * - ONE adult dose (covering A,C,Y,W-135) is **MANDATORY for NEW students living in University Residence Halls** - (given within the last 5 years) *The vaccine remains optional for all other students at the current time.*

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

DOCUMENTATION OF REQUIRED IMMUNIZATIONS

STUDENT NAME (PRINT NAME) _____

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

MMR (Combined Measles, Mumps, Rubella Vaccine) Month /Day /Year MMR # 1 ____/____/____ MMR # 2 ____/____/____
(2 full doses of MMR is preferred)

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 ____/____/____

Hepatitis B Series (Three (3) dose series) Month /Day /Year #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
(If you take 12 or more credits in your FIRST semester, you must complete the Hepatitis B series)

* Meningitis (Adult Meningococcal Meningitis Vaccine) ____/____/____ Name of Vaccine: _____

A booster dose of Meningitis Vaccine is required - if it has been greater than 5 years since the last dose.

** **Required by NJ law for NEW students living in University Residence Halls***

OPTION FOR BLOOD WORK: TITER (BLOOD) RESULTS FOR MMR or HEPATITIS B MAY BE SUBSTITUTED FOR IMMUNIZATIONS.

BUT MUST BE ACCOMPANIED BY A CLEAR COPY OF THE ORIGINAL LABORATORY REPORT

ONLY POSITIVE OR IMMUNE IGG REPORTS CAN BE ACCEPTED - EQUIVOCAL RESULTS CAN NOT BE ACCEPTED!

SEE AVAILABLE EXEMPTIONS ON REVERSE SIDE OF FORM

RECOMMENDED IMMUNIZATIONS - (Optional at the present time)

Meningitis ____/____/____ (within last 5 years) Name of Vaccine Given: _____

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

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

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

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: _____

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 report 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 or the Meningitis campus housing regulation.

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 clergy or parent. 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 *Nisseria 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 _____