



STUDENT HEALTH SERVICE
CASTLE POINT ON HUDSON
HOBOKEN, NJ 07030

TO THE STUDENT: This information is required of you to enable the College Health Service to provide medical care based on your particular health needs. This information becomes part of your medical record. All information in your medical record is confidential and will not be released without your written permission.

PLEASE TYPE OR PRINT IN INK

NAME _____ SEX: F [] M []
LAST FIRST MIDDLE

HOME ADDRESS _____ TEL. NO. () _____
NUMBER STREET

CITY STATE ZIP CODE

LOCAL ADDRESS _____ TEL. NO. () _____

SOCIAL SECURITY # _____ AGE _____ DATE OF BIRTH _____

MARITAL STATUS: Single [] Married [] Separated [] Divorced [] Widowed []

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME _____ RELATIONSHIP _____ HOMEPHONE _____
BUS. PHONE _____
NAME _____ RELATIONSHIP _____ HOMEPHONE _____
BUS. PHONE _____

HEALTH & HOSPITALIZATION INSURANCE

Name of Health & Hospitalization Insurance Company _____

Name of insured _____ Policy number _____

Coverage Code (if any) _____ Group number (if any) _____

MEDICAL RELEASE

In case of routine health examinations, diagnostic procedure and treatment of illness and/or injuries, permission is hereby granted to treat the student named above at the Student Health Center of Stevens Institute of Technology and to make necessary referrals to private physicians and other community facilities as indicated. It is understood that every effort will be made to contact the parent or guardian in case of a serious illness or if surgery is indicated.

Signature of Student _____ Date: _____

Signature of Parent or Guardian _____ Date: _____
(Signature of parent or guardian required for all students under 18 years of age)

REPORT OF MEDICAL HISTORY

PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

PERSONAL HISTORY (Please check if you have had any of the following)

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Night Sweating |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glasses / Contact Lens | <input type="checkbox"/> Recent weight gain or loss/how much _____ lbs. |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injury / Concussion | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Hearing Aid (s) | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> Heart Problem / Murmur | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tonsillitis (Chronic) |
| <input type="checkbox"/> Convulsion | <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Unexplained Aches & Pains |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Use smokeless / Chewing tobacco |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Smoke Cigarettes, Cigars or Pipe |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Migraine / Frequent | How many years _____ |
| <input type="checkbox"/> Muscle Disorder | <input type="checkbox"/> Severe Headaches | How many a day _____ |

Other medical conditions that you believe we should be aware of ? (Please explain) _____

List any allergies _____

Have you ever been hospitalized ? Had any operations ? (please note details) _____

List all current medications _____

List any serious injury _____

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER (S)					
SISTER (S)					

Has any of your immediate family ever had any of the following ? (Please state relationship)

- Cancer _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Kidney Problems _____
- Tuberculosis _____
- Other _____

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

Signature of Student _____

Date _____

STUDENT HEALTH IMMUNIZATION RECORD

INTRODUCTION & DIRECTIONS:

New Jersey State Law (N.J.A.C. 8:57:6.1-6.13) requires all College students to submit evidence of vaccination to Measles, Mumps, and Rubella. To be in compliance with the immunization regulations you have three (3) options:

1. Have your physician or clinic complete the immunization information in Section A documenting the following immunizations; Measles (2 doses), Mumps and Rubella (1 dose each) or return a photocopy of your previously completed immunization records. If Section A is not completed, and previous records are not supplied:
2. Claim an application exemption in Section B (side 2). If unable to claim an exemption:
3. You must be immunized for Measles (2 doses), Mumps and Rubella (1 dose each), and have a physician / clinic complete Section A.

GENERAL INFORMATION (please complete fully)

- Undergraduate Graduate
 Full Time Part Time International

Name _____
Last First M.I.

Social Security Number _____ Date of Birth _____ Sex _____

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

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

Phone (Home) _____ (Work) _____ (Local) _____

SECTION A - CERTIFICATION OF IMMUNIZATION

NOTE: All immunizations must have been given after 1st birthday and after 1968 to be VALID.

This section must be completed by a physician or health care provider or attach a copy of your records.

Measles	(2 doses)	1. _____	2. _____	3. _____
Mumps	(1 dose)	1. _____	2. _____	3. _____
Rubella	(1 dose)	1. _____	2. _____	3. _____
MMR		1. _____	2. _____	3. _____

Signature and / or Office Stamp _____ Date _____
(Physician, Public Health Official, School Nurse)

Address _____ Phone # _____

SECTION B - EXEMPTIONS

If you have not completed Section A and are unable to locate your immunization records, you may opt to claim one of the following exemptions where applicable.

If you have not claimed an exemption in Section B, and are unable to provide your previous immunization records, you must be currently immunized for Measles (2 doses), Mumps, & Rubella (1 dose).

Make sure to return the required proof stated for the chosen exemption to the Student Health Services Department (not the Admissions Office)

Age Exemption

Born prior to January 1, 1957
Attach copy of birth certificate

Religious Exemption *(N.J.A.C. 8:58-6.8)

Attach letter from accredited Religious leader in your church or religious group

Medical Exemption * (N.J.A.C. 8:57-6.7)

(Must be reviewed annually to determine continuation of exemption)
Physician's statement explaining why you cannot be immunized at this time is required. Statement must include diagnosis. If pregnant, indicate you due date.

Immune Status (Measles, Mumps antibody & Rubella titers)

Laboratory blood results showing that you are immune are required.

* Please note that students claiming the religious or medical exemption may be prohibited from attending classes and / or college activities in case of an outbreak or at the discretion of the Department of Health.

Return your completed Immunization Record promptly to:

Student Health Service
Stevens Institute of Technology
Castle Point on Hudson
Hoboken, New Jersey 07030



Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201.216.5678
Fax: 201.216.5677

Student Health Services

Meningococcal Disease Among College Students

Information Sheet

On May 11, 2000, Governor Whitman signed Senate Bill 808 into law. This law requires all four-year institutions of higher education to 1) provide information about meningitis disease and the availability and benefits of a meningitis vaccine to all their full and part-time incoming freshmen, transfer, and graduate students prior to matriculation; 2) to develop a system to distribute meningitis information; and 3) to record the enrolling student's decision whether or not to receive a meningitis vaccination. This law does not require that incoming students receive the meningitis vaccination. The law does not require that a college student health service directly provide or pay for meningitis vaccination.

It is recommended that the American College Health Association brochure, (attached), be distributed to incoming students, which describes meningitis disease and the meningitis vaccine. In addition, it is required that students be referred to their private physician or other healthcare provider for administration of the meningitis vaccine, if so desired. There will also be a **Meningitis Vaccination Day at Stevens on October 25, 2001.**

I have received information about meningitis disease, the effectiveness of the vaccine, and the availability of a meningitis vaccine. Yes No

Check one below:

1. I have received the meningitis vaccine. _____
2. I have decided to receive the meningitis vaccine at some future time. _____
3. I have decided not to receive the meningitis vaccine. _____
4. I am undecided about whether or not to receive the meningitis vaccine. _____

Name _____ Date _____

Signature _____

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

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. THE STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his / her status: It will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Services and will not be released without student consent.

LAST FIRST MIDDLE SEX: F M

Blood Pressure _____ Height _____ Weight _____

TESTS REQUIRED FOR ALL STUDENTS

- A. TUBERCULOSIS SCREENING (PPD required regardless of prior BCG inoculation).
1. PPD (Mantoux) within the past 6 months (tine or monovac not acceptable)
Result: Neg _____ Pos _____ mm induration (horizontal diameter _____ / _____
Mo Yr
 2. If PPD is positive, chest X-ray required:
X-ray result: Normal _____ Abnormal _____ / _____
Mo Yr
 3. INH prophylaxis taken? Yes _____ No _____
- B. TETANUS / DIPHTHERIA Booster within last 10 years _____ / _____ / _____

TESTS RECOMMENDED FOR ALL STUDENTS

- A. HEPATITIS B VACCINE
1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
- B. MENINGOCOCCAL MENINGITIS recommended as follows: One dose preferably at entry into college for freshmen, transfer and graduate students living in dormitories or residence halls who wish to reduce his / her risk of meningococcal disease. Any student less than 25 years who wishes to reduce his / her risk of disease can consider the vaccine. Students with immunodeficiency such as complement deficiency or asplenia should receive the vaccine q3-5 yrs. (Please see enclosed brochure and information sheet) Date: _____
- C. VARICELLA (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)
1. History of Disease Yes _____ No _____
 2. Varicella antibody _____ / _____ Reactive _____ Non-reactive _____
Mo Yr
 3. Immunization
 - a. Dose #1 #1 _____ / _____
Mo Yr
 - b. Dose #2, given at least one month after first dose, #2 _____ / _____
if age 13 years or older Mo Yr

Please check abnormalities of following systems:

Describe fully:

- | | | |
|--|---|--|
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hernia | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Metabolic / Endocrine | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neuropsychiatric | <input type="checkbox"/> Head, Ears, Nose & Throat |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | |

Are there any recommendations / limitations regarding care / physical activities for this student?
(Physical Education, Intramurals) Explain: _____

Print Name

Address

Physician's Signature

RETURN ALL INFORMATION TO:
Student Health Service
Stevens Institute of Technology
Castle Point on Hudson
Hoboken, New Jersey 07030