



**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 COMPLETE IN INK. CONFIDENTIAL (TO BE COMPLETED BY STUDENT)**

NAME \_\_\_\_\_ SEX: F  M

LAST FIRST MIDDLE

PERMANENT ADDRESS \_\_\_\_\_ TEL. NO. ( ) \_\_\_\_\_

NUMBER STREET

\_\_\_\_\_

CITY STATE ZIP CODE

CITIZENSHIP \_\_\_\_\_ EMAIL \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ DATE ENTERING STEVENS \_\_\_\_\_

MONTH/YEAR

Undergraduate  Graduate  International  Full Time  Part Time  Transfer

Campus Resident (Living in campus owned housing)  Commuter

**PERSON TO CONTACT IN CASE OF EMERGENCY**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ ADDRESS: \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK ( ) \_\_\_\_\_ CELL ( ) \_\_\_\_\_

**INSURANCE INFORMATION**

Note: If you DO NOT wish to purchase the student health insurance offered by Stevens, students must provide their insurance information online to University Health Plans at [www.univhealthplans.com](http://www.univhealthplans.com) in order to waive the insurance premium. If students do not waive the insurance online, they will be responsible for the charges. PLEASE ATTACH A COPY OF ALL INSURANCE CARDS (front and back).

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 is required for all students under 18 years of age)*

I authorize the Stevens Student Health Center to contact me by me email address for notification purposes.

# REPORT OF MEDICAL HISTORY

Please complete this before going to your physician for examination.

**PERSONAL HISTORY** Do you now have or have you ever had:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Hearing Aid(s)                     | <input type="checkbox"/> Recent weight gain or loss<br>How much _____ lbs.                                |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Heart Problem/Murmur               | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hepatitis                          | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Alcohol/Drug Abuse     | <input type="checkbox"/> High Blood Pressure                | <input type="checkbox"/> Sinusitis  |
| <input type="checkbox"/> Back Problem           | <input type="checkbox"/> Infectious Mononucleosis           | <input type="checkbox"/> Skin Disorder  |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Kidney Problems                    | <input type="checkbox"/> Tonsillitis (Chronic)  |
| <input type="checkbox"/> Chronic Fatigue        | <input type="checkbox"/> Learning Disability                | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Lyme Disease                       | <input type="checkbox"/> Ulcer  |
| <input type="checkbox"/> Eating Disorder        | <input type="checkbox"/> Malaria                            | <input type="checkbox"/> Unexplained Aches & Pains  |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Meningitis                         | <input type="checkbox"/> Use smokeless/chewing tobacco  |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Migraine/Frequent Severe headaches | <input type="checkbox"/> Smoke cigarettes, cigars or pipe<br>How many years _____<br>How many a day _____ |
| <input type="checkbox"/> Fainting Spells        | <input type="checkbox"/> Muscle Disorder                    |   |
| <input type="checkbox"/> Frequent Cough         | <input type="checkbox"/> Night Sweating                     |   |
| <input type="checkbox"/> Glasses/Contact Lenses | <input type="checkbox"/> Psychological/Emotional Issues     |   |
| <input type="checkbox"/> Head Injury/Concussion |   |   |

Do you now have or have you ever had :

- Incidents of self-harming behavior     An abusive/controlling relationship     Sleep difficulties

If yes, please comment \_\_\_\_\_

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)

- |  |  |
|--|--|
| <input type="checkbox"/> Alcohol/Drug Abuse Issues _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cancer _____                    | <input type="checkbox"/> Kidney Problems _____     |
| <input type="checkbox"/> Diabetes _____                  | <input type="checkbox"/> Tuberculosis _____        |
| <input type="checkbox"/> Heart Disease _____             | <input type="checkbox"/> Other _____               |

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

Signature of Student \_\_\_\_\_ 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** — Signed statement explaining to the Student Health Center how the administration of the particular vaccine conflicts with Bona Fide religious tenets/beliefs. Exemptions are not given for philosophical or moral objections to immunization.

**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

MMR (Combined Measles, Mumps, Rubella Vaccine) *Month/Day/Year* MMR #1     /    /     MMR #2     /    /      
(2 doses required at least 28 days apart) Dose 1 given at 12 months or later Dose 2 given at least 28 days after first dose

MEASLES (Single Antigen Mumps 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     /    /    

- Born before 1957 and therefore considered immune.

**If documentation of vaccines is unavailable, an immune titer blood test is required (please include actual copy of results). If the titer does not indicate immunity (including equivocal immunity), vaccines are required.**

\* MENINGITIS (Meningococcal Meningitis Vaccine—Menomune or Menactra—1 dose)     /    /      
\*Required by NJ law for NEW students living in Stevens Residence Halls as of September 2004.

HEPATITIS B VACCINE: Series of 3 doses #1     /    /     #2     /    /     #3     /    /    

\*\* PPD - Mantoux Test (Tuberculin skin test) - required for all students within the past 6 months, regardless of BCG history. PPD is invalid without signature by provider, and the date read.

Test Date: \_\_\_\_\_ Date Read: \_\_\_\_\_ Results: \_\_\_\_\_ mm

Lot #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ MFR: \_\_\_\_\_

Copy of chest x-ray required if > 10mm. induration (horizontal diameter).

INH prophylaxis taken? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please provide documentation.)

Prior PPD history: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_ mm

\* \* Required by Stevens Institute of Technology

# RECOMMENDED (OPTIONAL AT THE PRESENT TIME)

TETANUS/DIPHTHERIA: (within the last 10 years) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

VARICELLA (Chicken Pox): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## FORMS WITHOUT SIGNATURES AND THE REQUIRED INFORMATION WILL BE CONSIDERED INCOMPLETE

Signature of Health Care Provider \_\_\_\_\_

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

Address \_\_\_\_\_

Ph # ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_

Office Stamp \_\_\_\_\_ Date \_\_\_\_\_

**Where can you obtain an acceptable record of your immunizations?** Students are responsible for contacting the various agencies or institutions and for requesting a copy of their immunization records.

**All records MUST be in English or accompanied by a translation.**

1. 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.
2. Personal Immunization Record: Records from pediatricians or family medical providers are acceptable, if verified (with stamp or signature), and contain proof of minimum requirements.
3. Local Health Department: If primary immunizations were received at a local health department, a copy may be obtained from this source.

# INFORMATION ON MENINGOCOCCAL DISEASE & VACCINATION

The New Jersey Department of Health and Senior Services (NJAC 8:57-6.6) requires that NJ colleges and universities provide incoming students with information about meningococcal disease and the meningococcal vaccine.

## Meningococcal Disease Information

Please read the information below on Meningococcal Disease and respond to the following “I have received information about Meningococcal disease, the effectiveness of the vaccine, and the availability of the meningococcal vaccine.”

- Yes                       No

## Meningococcal Vaccine

- I will be residing on campus. I am therefore required by law and Stevens immunization policy to receive a meningococcal meningitis vaccine. At this time I have either received the vaccine (enter date on Immunization Record) or I plan to receive the vaccine prior to submission of this form.
- I will not be residing on campus, but I have already received the vaccine (enter date on Immunization Record), or I plan to have the vaccine at some future time.
- I will not be residing on campus and I have decided to not receive the meningococcal meningitis vaccine.
- I will not be residing in campus housing and I am undecided about receiving the meningococcal meningitis vaccine.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian signature (if student is under 18 years of age): \_\_\_\_\_

New Jersey State Law requires that new students attending N.J. colleges and universities receive the Meningococcal Meningitis A, C, Y, W-135 vaccine prior to entering campus housing.

Meningitis is an infection of the spinal cord fluid and the fluid surrounding the brain. There are two major types of meningitis: The most common is viral meningitis, which can be caused by a variety of viruses. While viral meningitis may be a serious illness people usually recover completely in several days.

The other type, bacterial meningitis, is caused by several kinds of bacteria. The most serious is *Neisseria Meningitidis*, which cause Meningococcal meningitis. Meningococcal disease is the leading cause of bacterial blood stream infection and meningitis in children and young adults in the United States. Surveillance of Meningococcal disease among U.S. college students found a *modestly elevated rate of this disease among first-year students living in residence halls*. Data has also suggested that certain social behaviors such as, exposure to passive and active smoking, bar patronage and excessive alcohol consumption may increase students' risk for contracting the disease.

Though rare, the effects of Meningococcal disease can be devastating. Despite treatment with appropriate intravenous antibiotic and optimal medical care, the overall fatality rate of meningococcal meningitis is 9 to 12 percent, with a rate of up to 40 percent among patients with meningococcal blood stream infection. Eleven to 19 percent of survivors of meningococcal disease have permanent injury, such as hearing loss, neurologic disability, or loss of a limb.

One of the challenges of diagnosing Meningococcal disease is that its symptoms are difficult to distinguish from those of more common but less serious illnesses. Generally, symptoms include a sudden onset of headache, fever, and stiffness of the neck sometimes accompanied by nausea, vomiting, light sensitivity, confusion, or a purplish rash. *This illness can progress rapidly with tragic consequences in a few hours unless appropriate intravenous antibiotic treatment is started shortly after the symptoms begin.*

Most cases of Meningococcal disease occur sporadically or as individual cases without apparent connection to any case or person. Persons directly exposed to an infected person's oral secretions (i.e., kissing, mouth-to-mouth resuscitation) are at elevated risk for contracting the disease. Meningococcal bacteria is NOT spread through casual contact. Persons who have had close contact with the oral secretions of an infected person need post-exposure antibiotic therapy preferably within 48 hours to prevent the disease. This even includes those who have received the Meningococcal meningitis vaccine.

The best way to decrease the risk of Meningococcal disease is vaccination. Currently, there are two Meningococcal vaccines licensed and available in the U.S. The preferred Meningococcal vaccine is the CONJUGATE type (in the U.S. Menactra™ Sanofi Pasteur); however, the polysaccharide type of the vaccine (in the U.S., Menomune® Sanofi Pasteur) is acceptable as long as vaccination occurred within 3 years of college entry. If not, a repeat vaccination must be obtained. Meningococcal vaccination is 85 to 100 percent effective against four of the five most common types of the bacteria that cause the disease. Studies show that up to 80 percent of cases of Meningococcal meningitis on college campuses are vaccine-preventable.

It is important for recipients of the Meningococcal vaccine to remember that no vaccine offers 100% protection. The Meningococcal vaccine consists of only 4 of the 5 most common types of Meningococcal disease. This means that the vaccine does not offer protection against all types of Meningococcal bacteria that cause this disease. In addition, not all cases of meningitis are caused by Meningococcal bacteria. Therefore, if symptoms of meningitis should develop, a vaccinated person should still seek medical attention.

Contact your healthcare provider for additional vaccine information, or call the Stevens Health Center at (201) 216-5678.



PLEASE DISCUSS THIS FORM WITH YOUR PRIMARY  
CARE PROVIDER AND REMEMBER TO MAIL IT BACK TO:

**STEVENS STUDENT HEALTH CENTER  
1 CASTLE POINT ON HUDSON  
HOBOKEN, NJ 07030**

**REMINDER!**

**If you do not wish to purchase the student health insurance offered by Stevens, you must provide your insurance information online at [www.univhealthplans.com](http://www.univhealthplans.com) in order to waive the insurance premium. If you do not waive the insurance online by the deadline, you will be responsible for the charges!**