



**STUDENT HEALTH & IMMUNIZATION RECORD**  
 STUDENT HEALTH CENTER . CASTLE POINT ON HUDSON . HOBOKEN, NJ 07030  
 201-216-5678

**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

HOME ADDRESS \_\_\_\_\_ TEL. NO. ( ) \_\_\_\_\_  
NUMBER STREET

\_\_\_\_\_  
CITY STATE ZIP CODE

LOCAL ADDRESS \_\_\_\_\_ TEL. NO. ( ) \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_

STEVENS ID# \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

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 ( ) \_\_\_\_\_

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

**PERMISSION TO USE EMAIL ADDRESS**

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)                     | 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 |
| <input type="checkbox"/> Fainting Spells        | <input type="checkbox"/> Muscle Disorder                    | How many years _____                                      |
| <input type="checkbox"/> Frequent Cough         | <input type="checkbox"/> Night Sweating                     | How many a day _____                                      |
| <input type="checkbox"/> Glasses/Contact Lenses | <input type="checkbox"/> Psychological/Emotional Issues     |   |
| <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Recent weight gain or loss         |   |

Do you now have or have you ever had :

- Suicide attempts                       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.

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**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 \_\_\_/\_\_\_/\_\_\_

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.

\* 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 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.

# 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 on the next page.

All NEW students (residing in campus housing) as of September 2004 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 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.**

**CONTACT YOUR HEALTH CARE PROVIDER FOR ADDITIONAL VACCINE INFORMATION.**

# MENINGITIS SURVEY

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) \_\_\_\_\_

Social Security No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Administered by \_\_\_\_\_

*(Signature of Health Care Provider)*

Signature \_\_\_\_\_

Date \_\_\_\_\_



# **STOP! DID YOU REMEMBER TO FILL OUT YOUR MENINGITIS SURVEY?**

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

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