STUDENT HEALTH & IMMUNIZATION RECORD

STUDENT HEALTH SERVICES . CASTLE POINT ON HUDSON . HOBOKEN, NJ 07030 .T: 201-216-5678 . F: 201-216-5677

TO THE STUDENT: This information is required of you to enable the College Health Services 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) **STEVENS CWID#** _____

NAME_____
LAST/FAMILY FIRST MIDDLE

PERMANENT ADDRESS_____
NUMBER STREET

_____**TEL. NO.** ( )_____
CITY STATE ZIP CODE

CITIZENSHIP_____**STEVENS EMAIL**_____**CELL. NO.** ( )_____

AGE_____**DATE OF BIRTH**_____**DATE ENTERING STEVENS**_____

Starting Semester Fall ☐ Spring ☐ Summer ☐ Year_____

CHECK ALL THAT APPLY:
Undergraduate ☐ Graduate ☐ International ☐ Domestic ☐ Full Time ☐ Part Time ☐ Transfer ☐

Campus Resident (Living in campus or leased housing) ☐ Commuter ☐

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME_____RELATIONSHIP_____ADDRESS_____

HOME PHONE ( )_____WORK PHONE ( )_____CELL PHONE ( ) _____

INSURANCE INFORMATION

STEVENS STUDENT HEALTH INSURANCE ☐ PRIVATE INSURANCE ☐ BOTH ☐

PLEASE ATTACH A COPY OF ALL INSURANCE CARDS (FRONT AND BACK)

CONSENT AND RELEASE

In case of diagnostic procedure and treatment of illness and/or injuries, permission is hereby granted to treat the student named below at Student Health Services 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_____

***IF YOU ARE UNDER 18 YEARS OF AGE, SIGNATURE OF A PARENT/LEGAL GUARDIAN IS REQUIRED**

SIGNATURE OF PARENT/LEGAL GUARDIAN_____DATE_____

☐ I authorize the Stevens Health Services to contact me by my email address for notification purposes.

STUDENT NAME_____

STEVENS CWID_____

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:

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Alcohol/Drug Abuse
- ❑ Back Problem
- ❑ Cancer
- ❑ Chronic Fatigue
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Frequent Cough
- ❑ Glasses/Contact lenses
- ❑ Head Injury/Concussion
- ❑ Hearing Aid
- ❑ Heart Problem
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Infectious Disease
- ❑ Kidney Problems
- ❑ Learning Disability
- ❑ Lyme Disease
- ❑ Malaria
- ❑ Meningitis
- ❑ Migraine/Frequent Severe Headaches
- ❑ Muscle Disorder
- ❑ Night Sweats
- ❑ Recent Weight gain or loss
  How much?_____lbs.
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sinusitis
- ❑ Skin Disorder
- ❑Tonsillitis (Chronic)
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Unexplained Aches & Pains
- ❑ Use Smokeless/Chewing Tobacco
- ❑ Smoke cigarettes, cigars, pipe Vape
  How many years? _____
  How many a day? _____

Do you now or have you ever had:

- ❑ Sleep difficulties

If yes, please comment_____

_____

Other medical conditions, injuries, hospitalizations, or surgeries that you believe we should be aware of? (Please explain)

_____

_____

List any allergies_____

List all current medications _____

FAMILY HISTORY (optional)

	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)

- ❑ Alcohol/Drug Abuse Issues_____
- ❑ 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_____

MENTAL HEALTH HSITORY

STUDENT NAME_____
STEVENS CWID _____

Please note: answering the questions on this page is entirely optional. These questions are being asked as a way for students to self-disclose current or past history of mental health concerns and to engage proactively in conversations about caring for their emotional well-being during their time at Stevens.

(1)	Are you currently receiving psychotherapy from a mental health professional?	Yes	No	Prefer not to answer
(2)	Have your previously received psychotherapy from a mental health professional?	Yes	No	Prefer not to answer
(3)	Are you currently under the care of a psychiatrist or other health professional who prescribes medication to treat an emotional condition?	Yes	No	Prefer not to answer
(4)	Have you previously been under the care of a psychiatrist or Other health professional who prescribes medication to treat an emotional condition?	Yes	No	Prefer not to answer

Would you like to be contacted by the Office of Counseling and Psychological Services (CAPS) to begin a discussion about proactively planning your emotional well-being during college? Yes ☐ No ☐

PERMISSION FOR RELEASE OF INFORMATION TO STUDENT COUNSELING

By signing below, you (the above-named student) are consenting to have the health information shared on this page be released by the staff of Stevens Health Services (SHS) to the Stevens Office of Counseling and Psychological Services (CAPS). *Please note that signing this consent is optional.* The sole purpose of sharing your information in this manner is so that a professional at CAPS may reach out to you to have a conversation about ways to proactively address your emotional well-being during your time at Stevens.

I have read the above statement and agree to provide permission as requested above. I understand that this permission can be revoked by written notice to both facilities at any time.

_____ ___/___/___ ____/____/____
Signature Date of Birth Today's Date

FOLLOW-UP BY CAPS

Please be aware that CAPS may follow up by emailing or calling you to have a discussion. Some students refer that messages from Student Counseling not be left on their phones or emails. Please indicate your preferences below:

Email me @ _____

Call me at @ (____) _____ - _____

Check here ☐ if you prefer CAPS *not* leave a message.

Meningococcal Disease for College Students

New Jersey law requires that certain students receive meningococcal vaccines!

Are you protected?

Students attending college are at higher risk of getting meningococcal disease, especially first-year students living in residence halls.

Get vaccinated!

What is meningococcal disease?

Meningococcal (muh-nin0jo-cok-ul) disease is a serious bacterial infection caused *Neisseria meningitidis*. The bacteria can invade the body, leading to severe swelling of the tissue surrounding the brain and spinal cord (meningitis) or bloodstream infection. Both of these types of infections are very serious and can be deadly in a matter of hours. Even with antibiotic treatment, 10 to 15 in 100 people infected with meningococcal disease will die. Up to 1 in 5 survivors will have long-term disabilities, such as loss of limb(s), deafness, nervous system problems, or brain damage.

How do people get meningococcal disease?

People spread meningococcal bacteria by sharing respiratory and throat secretions (saliva/spit). Generally, the bacteria are spread by close or lengthy contact with a person who has meningococcal disease such as:

- People in the same household
- Roommates
- Anyone with direct contact with the patient's oral secretions such as through kissing or sharing eating utensils, cigarettes/vaping devices, and food.

What are the symptoms of meningococcal disease?

Symptoms can progress quickly and may include:

- high fever
- headache
- stiff neck
- confusion
- sensitivity to light
- nausea
- vomiting
- exhaustion
- purplish rash

Some people carry the bacteria in their noses and throat, but they don't become ill. Even though they do not have symptoms, they can still spread the bacteria to others.

How can I protect myself from meningococcal disease?

The best way to protect yourself from meningococcal disease is to **get vaccinated**. There are two types of meningococcal vaccines that protect against the common serogroups (A, B, C, W, Y) of the bacteria:

- Meningococcal conjugate or MenACWY vaccines (Menveo® or Menactra®)
- Serogroup B meningococcal or MenB vaccines (Bexsero® or Trumenba®)

NJ Health New Jersey Department of Health

NJCDS New Jersey Communicable Disease Service

For more information, please visit https://nj.gov/health/cd/topics/meningo.shtml, or contact the NJDOH Vaccine Preventable Disease Program at 609-826-4861.

STUDENT NAME_____
STEVENS CWID _____

MENINGOCOCCAL VACCINATION REQUIREMENT QUESTIONNAIRE

As a new student enrolling in a public or private institution of higher education in New Jersey, you are required by state law (P.L.2019, C.332 (N.J.S.A 18A:62-15.1) to receive meningococcal vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) as a condition of college attendance.

There are 2 types of meningococcal vaccines available in the United States:

- Meningococcal Meningitis ACWY (MenACWY) vaccines (Brand names are Menactra® and Menveo®): Routinely received at ages 11-12 years with a booster dose at 16 years. Adolescents who receive their first dose of MenACWY on or after their 16th birthday do not need a booster dose. Additional doses may be recommended based on risk. People 19 years of age and older are not routinely recommended to receive the MenACWY vaccine unless they are living in college housing or if another risk factor applies.
- Meningococcal Meningitis B (MenB) vaccines (Brand names are Bexsero® and Trumenba®): Routinely recommended for people ages 10 years and older with high-risk health conditions. People 16-23 years old (preferably at ages 16-18 years) may also choose be vaccinated against MenB.

To find out what type of meningococcal meningitis vaccine(s) you will need to attend Stevens, please answer the following questions. Be sure to show this form to your healthcare provider so that these vaccinations can be noted on your record of vaccination.

You will need <u>Meningococcal Meningitis ACWY</u> vaccination if you answer YES to one or more of the age and risk factor questions below.

1. Are you 18 years of age or younger — yes ☐ no ☐
2. Are you 19 years of age or older and plan to apply for college housing? — yes ☐ no ☐
3. Do you have a rare type of immune disorder called complement component deficiency or Human Immunodeficiency Virus (HIV)? — yes ☐ no ☐
4. Are you taking a type of medicine called a complement inhibitor (for example, Soliris* or Ultomiris *) — yes ☐ no ☐
5. Has your spleen been removed or do you have a damaged spleen, including sickle cell disease? — yes ☐ no ☐

You will need <u>Meningococcal Meningitis B</u> vaccination if you answer YES to one or more of the risk factor questions below.

1. Do you have a rare type of immune disorder called complement component deficiency? — yes ☐ no ☐
2. Are you taking a type of medicine called a complement inhibitor (for example Soliris* or Ultomiris*)? — yes ☐ no ☐
3. Has your spleen been removed or do you have a damaged spleen-including sickle cell disease? — yes ☐ no ☐

I verify that the information provided by me on this form is true._____**Date**_____
Student's signature (or parent/legal guardian if minor)

Though Meningococcal Meningitis B vaccination is not required for persons 16-23 years of age, you may choose to receive Men B vaccine to provide short-term protection against most strains of Men B disease. Learn more about meningococcal disease and Men B vaccination at www.cdc.gov/meningococcal. Please consult with your healthcare provider if you have questions about the meningococcal vaccines or if you need to receive the vaccines to attend Stevens.

Name:_____ **Birth date:** ____/___/____ **STEVENS CWID** _____

STUDENT NAME_____
STEVENS CWID_____

IMMUNIZATION RECORDS

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 Services 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.

***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.**

MEASLES, MUMPS, RUBELLA (MMR)

- 2 doses of vaccine administered, on or after 12 months of age, and at least 28 days apart are required, OR
- Laboratory proof of immunity; copy of Measles (Rubeola), Mumps, and Rubella Virus IgG Antibody laboratory titer report MUST be attached if submitting in lieu of immunization dates. EQUIVOCAL RESULTS NOT ACCEPTABLE.

MEASLES, MUMPS, RUBELLA (MMR): REQUIRED

- 2 doses of vaccine administered, on or after 12 months of age, and at least 28 days apart are required, **OR**
- Laboratory proof of immunity; **c**opy of Measles (Rubeola), Mumps, and Rubella Virus IgG Antibody laboratory titer report MUST be attached if submitting in lieu of immunization dates. *EQUIVOCAL RESULTS NOT ACCEPTABLE*.

MMR Dose 1:____/___/ ____ M D Y **MMR Dose 2:**_____/____/_____ M D Y	**OR**	**Must attach MEASLES, MUMPS AND RUBELLA IgG Titer Lab Report Showing positive immunity.**	**OR**	**MEASLES :**1: ____/____/___ 2:____/____/___ M D Y **MUMPS :** 1: ____/____/___ 2:____/____/___ M D Y **RUBELLA :** 1: ____/____/___ 2:____/____/___ M D Y	

VARICELLA (Chicken Pox)- REQUIRED FOR ALL STUDENTS

2 doses of VARICELLA VACCINE REQUIRED Dose #1 Received: ___/___/___ M D Y Dose #2 Received: ___/___/___ M D Y	**OR**	**Laboratory Documentation of Immunity** **Varicella Zoster Virus (VZV) IgG Antibody test** **Copy of Laboratory report must be attached.**	**History of Chicken Pox?** Infection or history of herpes zoster, based on health care provider diagnosis Date: _____/_____ M Y

STUDENT NAME_____
STEVENS CWID_____

HEPATITIS B - a copy of a Hepatitis B IgG Surface Antibody (anti-HBc) laboratory titer report MUST be attached if submitting in lieu of immunization dates. *EQUIVOCAL RESULTS NOT ACCEPTABLE*.			
HEPATITIS B vaccine Dose 1: ___/___/___ Dose 2: ___/___/____ Dose 3: ___/___/____ M D Y	**HEPATITIS A and B combined** Dose 1: ____/___ /____ Dose 2: ____/___ /____ Dose 3: ____/___ /____ M D Y	**Must attach** **HEPATITIS B IgG Titer Lab Report showing positive immunity.**	**REQUIRED FOR ALL:** **FULL-TIME UG STUDENTS - taking 12 or more credit hours; and GRAD STUDENTS enrolled in 9 or more credits.**

TETANUS, DIPHTHERIA, PERTUSSIS vaccination (Tdap): Required		
TETANUS – Booster in the last 10 years.		
Tdap Dose: ____/____/____ M D Y	**or**	**TD** Dose: ____ /____/____ M D Y

REQUIRED MENINGITIS New Jersey State law requires that all students receive **Meningococcal A,C,Y, and W-135 vaccine**. Students will NOT be permitted entry to housing unless Health Services receives proof of vaccination. We accept Menactra, and Menveo. If the initial dose was administered before the 16th birthday, a booster dose should be administered after the 16th birthday. The minimum interval between doses of meningococcal conjugate vaccine is 8 weeks.

MENINGOCOCCAL MENINGITIS – VACCINE MUST BE ADMINISTERED ON OR AFTER 16th BIRTHDAY. **BOOSTER DOSE may be required if administered more than 5 years prior to the start of classes.** *****You will not be permitted to move into campus housing without this information*****				
MENINGOCOCCAL A, C, Y,W-135 (Menactra or Menveo) Dose 1:___/___/___ Dose 2:___/___/___ M D Y	**REQUIRED FOR ALL:** • **18 & YOUNGER** • **RESIDING IN CAMPUS HOUSING** • **AS INDICATED BY MENINGITIS QUESTIONNAIRE FORM**	**MENINGOCOCCAL B**		**REQUIRED AS INDICATED BY MENINGITIS QUESTIONNAIRE FORM**
		Bexsero 1:___/___/___ 2:___/___/___ M D Y	**Trumemba** 1:___/___/___ 2:___/___/___ 3:___/___/___ M D Y	

In addition to the above immunizations the following are recommended.			
Hepatitis A 1: ____/_____/_____ 2: ____/_____/_____ M D Y	**HPV** Dose 1:_____/_____/_____ Dose 2:_____/_____/_____ Dose 3:_____/_____/_____ M D Y	**Pneumococcal** _____/_____/_____ M D Y	**Influenza** _____/_____/_____ M D Y

STUDENT NAME_____

STEVENS ID_____

****PPD – Mantoux OR Interferon-based Assay TB Blood Test (Quantiferon Gold or T-spot) If Quantiferon Gold or T-Spot:**
(Must be performed within last year)

Result_____ (Attach copy of laboratory report)

If PPD-Mantoux Skin Test: (Must be performed within 6 months of entrance to Stevens)

Test Date:_____Date Read:_____Results:_____mm

Copy of chest x-ray required if: PPD is ≥ 10mm. induration (horizontal diameter) **OR** if Interferon-based Assay Blood Test is Positive

INH Therapy taken? Yes____No____(If yes, please provide documentation).

Prior PPD history: Date:_____Results:_____mm

**** Required by Stevens Institute of Technology OR WITHOUT SIGNATURE, OFFICE STAMP 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.

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 Health Services and will not be released without student consent.

STUDENT'S NAME _____ _____
LAST/FAMILY FIRST MIDDLE

Blood Pressure_____ Pulse_____ Height_____ Weight_____

Please check abnormalities of following systems. (Describe fully)
Are there any recommendations/limitations regarding care/physical activities for this student?

- ☐ Cardiovascular
- ☐ Metabolic/Endocrine
- ☐ Genitourinary
- ☐ Respiratory
- ☐ Psychological
- ☐ Hernia
- ☐ Gastrointestinal
- ☐ Neurological
- ☐ Skin
- ☐ Eyes
- ☐ Musculoskeletal
- ☐ HEENT

(Physical Education, Intramurals) Explain: _____

_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

_____
Print Name

_____
Address

_____
Physician's Signature

_____
Office Stamp

Return all information 30 days before you start classes via email:

Student Health Services
Stevens Institute of Technology
1 Castle Point on Hudson
Hoboken, NJ 07030

Email: studenthealthcenter@stevens.edu

PLEASE DISCUSS THIS FORM WITH YOUR PRIMARY CARE PROVIDER

Requirements Checklist:

- Copy of front and back of insurance card(s)
- Pages 1, 2, 3 & 5 must be signed by student or parent/legal guardian if student is under 18 years of age
- Pages 6, 7 & 8 must be completed in **English**, signed, and stamped by physician/healthcare provider
- Laboratory results (if needed as per the immunization records form)

UPON COMPLETION, REMEMBER TO RETURN ALL INFORMATION VIA EMAIL:

Student Health Services
Stevens Institute of Technology
1 Castle Point on Hudson
Hoboken, NJ 07030

Email: studenthealthcenter@stevens.edu

REMINDER!

If you do not wish to purchase the student health insurance offered by Stevens, you must provide your insurance information online at www.universityhealthplans.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!

Please check the website starting in July for the deadline and waiver.

WEBSITES YOU SHOULD KNOW:

For information about Student Health Services:
www.stevens.edu/health

For information about Counseling and Psychological Services (CAPS): www.stevens.edu/counseling

For information about Disability Services Office (ODS): www.stevens.edu/office-disability-services

For information about Student Health Insurance:
www.universityhealthplans.com and then click on "Stevens"