GEORGIAN COURT UNIVERSITY
THE MERCY UNIVERSITY OF NEW JERSEY

Health Services
900 Lakewood Avenue
Lakewood, NJ 08701-2697
healthservices@georgian.edu

Tel: 732.987.2756
Fax: 732.987.2014
www.georgian.edu

STUDENT HEALTH FORM

Please mail all completed, signed documents together in one envelope to:
Georgian Court University, **Health Services***, 900 Lakewood Avenue, Lakewood, NJ 08701*

ALL STUDENTS ARE REQUIRED TO COMPLETE THE STUDENT HEALTH FORM AND SUBMIT IT TO HEALTH SERVICES BEFORE CLASSES BEGIN.

PLEASE PRINT ALL INFORMATION IN INK, except where a signature is required.

Last Name _____ **First Name**_____ **M.I.** _____

Maiden/Former Name _____ **Last 4 Digits of SSN#** _____ **Date of Birth** ____/____/____ **Sex** _____

Address _____
(Permanent Home) Street City/Town State Country Zip

Phone: (home) _____ **(cell)**_____ **(work)** _____

Email _____ ☐ **I would like to receive important text messages from Health Services**

Please check boxes which apply to you:

☐ Campus Resident (living on campus) ☐ Commuter (living off campus in relatives or own home)
☐ Undergraduate ☐ Graduate

The semester you will begin attending Georgian Court: ☐ Fall ☐ Spring ☐ Summer Year _____

Previous student at Georgian Court? ☐ Yes ☐ No If yes, when? _____

PERSON TO NOTIFY *IN CASE OF EMERGENCY*

Name _____ **Relationship** _____

Phone: (home) _____ **(cell)** _____ **(work)** _____

STATEMENT OF CONFIDENTIALITY

Health records at the Office of Health Services are confidential and will not be released without written authorization from the student or pursuant to government authorization. Immunization records are not considered confidential.

CONSENT FOR TREATMENT

By signature, I verify that the information on this form is true, and I give permission for such diagnostic, therapeutic and operative procedures as may be deemed necessary for me.

_____
Signature Print Name Date

STUDENTS UNDER 18 YEARS OF AGE

I authorize Georgian Court University to administer medical and surgical services, immunizations and therapeutic procedures as deemed necessary by duly licensed personnel.

_____
Parent or Guardian's Signature Relationship Date

FAMILY HISTORY (Please use the COMMENTS section if additional details are needed for clarification.)
Please check the appropriate boxes if blood-related parent or sibling has a present or past history of:

Condition	Mother	Father	Sibling
Alcohol/Drug Abuse	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Deceased (age____)	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐

Condition	Mother	Father	Sibling
High Blood Pressure	☐	☐	☐
Kidney Disease	☐	☐	☐
Mental/Emotional Illness	☐	☐	☐
Stroke	☐	☐	☐
Tuberculosis	☐	☐	☐

PERSONAL HEALTH HISTORY (Please use the COMMENTS section if additional details are needed for clarification.)
Please check the appropriate boxes if you have a present or past history of:

- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Disability/Handicap
- ☐ Ear Trouble/Hearing Loss
- ☐ Eating Disorder
- ☐ Eye Disease/Vision Problems
- ☐ Gallbladder Trouble
- ☐ Head Injury
- ☐ Heart Disease/Problems
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hospitalization (list details below)
- ☐ Intestinal/Stomach Trouble
- ☐ Kidney Disease/Bladder Problems
- ☐ Lyme Disease
- ☐ Menstrual Problems
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Muscle, Joint/Bone Disorder
- ☐ Operations or serious injuries (list details below)
- ☐ Pneumonia
- ☐ Paralysis
- ☐ Psychological/Emotional
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sickle Cell Trait/Anemia
- ☐ Sinus Trouble
- ☐ Skin Disorder
- ☐ Sleep Difficulties
- ☐ Smoking/Tobacco Use
- ☐ Thyroid Disease
- ☐ Tuberculosis

Are there other aspects of your health that might cause **problems** for you or **require special arrangements** at Georgian Court University?
If so, please explain: _____

_____

_____

MEDICATIONS TAKEN REGULARLY (Include all prescription as well as over-the-counter medications and herbal)

Medication	Dosage	Frequency
Medication	Dosage	Frequency
Medication	Dosage	Frequency

DRUG ALLERGIES (Please specify name of drug and reaction)

_____

_____

ALLERGIES (Please specify; inlcude food, insect and environmental allergies)

_____

_____

☐ **PLEASE CHECK IF YOU ARE REQUIRED BY YOUR PHYSICIAN TO CARRY AN EPI PEN**

COMMENTS: _____

_____

_____

_____

MENINGITIS SURVEY

This survey MUST be completed by ALL students as required by New Jersey State Law, P.L.2000c.25.

Please read the information about meningitis below and then check ONE of the following boxes:

- ☐ I have decided to receive the meningitis vaccine now or in the future (required for ALL campus residents).
- ☐ I have decided not to receive the meningitis vaccine.
- ☐ I am undecided about whether or not to receive the meningitis vaccine.
- ☐ I have already received the meningitis vaccine.

The American College Health Association and the New Jersey Department of Health now recommend that ALL college students under the age of 25 consider getting vaccinated against meningococcal meningitis.

Meningococcal meningitis is a contagious, potentially life-threatening bacterial infection that causes inflammation of the membranes that surround the brain and spinal cord. Permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure or death can result from the infection. Early symptoms can be easily misdiagnosed as a viral illness, like influenza, but once it starts, meningococcal can progress very rapidly and can cause death within 48 hours. Although the disease is rare, outbreaks of meningitis on college campuses have risen in recent years. While the reasons are not yet fully understood, students residing in campus residences are at higher risk than college students overall.

Vaccination is an effective way for students to protect themselves against possible infection. The vaccine is 85 to 100% effective in preventing four strains of meningococcal disease (A, C, Y, W-135), which together account for nearly 70% of meningococcal cases on campuses. Menactra® and Menveo® are two of the meningococcal conjugate A, C, Y, W-135 vaccines licensed in the U.S. Meningitis C vaccine is NOT acceptable as a substitute for A, C, Y, W-135.

HEALTH & PRESCRIPTION INSURANCE INFORMATION

☐ **EPO** ☐ **POS** ☐ **HMO** ☐ **PPO** ☐ **NJ Family Cares** ☐ **NJ Medicaid** ☐ **No health insurance**

Insurance Company: _____

Policy Holder: Last Name_____ First Name _____

Relationship to Student: ☐ Self ☐ Parent ☐ Other (specify): _____

Insurance Company Address: _____

Policy Number: _____ **Group Number (if any):** _____

In-Network Laboratory: ☐ Quest Diagnostics ☐ Lab Corp ☐ Both

Prescription Insurance Company: _____ **Phone Number:** _____

Rx BIN # (found on card): _____ **Rx GROUP # (found on card):** _____

Rx ID # (found on card): _____

IMMUNIZATION RECORD

New Jersey Law requires all students to fully comply with immunization requirements. Students who fail to comply will be blocked from subsequent semester registration and excluded from University housing.

Name _____ Date of Birth _____

A. REQUIREMENT FOR ALL STUDENTS BORN ON OR AFTER 1/1/1957.

MMR (MEASLES/MUMPS/RUBELLA) – 2 doses
FIRST dose given after 1968 and on or after 12 months of age; SECOND dose separated at least 28 days from first dose.

MMR #1 _____ / _____ / _____ (M D Y) **MMR #2** _____ / _____ / _____ (M D Y)

OR: ATTACH LABORATORY REPORT INDICATING POSITIVE VALUES OF IMMUNITY

HEPATITIS B
All students enrolling with 12 or more credits. 3 doses of vaccine, or 2 doses of adult vaccine in adolescents 11-15 years of age.

#1 _____ / _____ / _____ (M D Y) **#2** _____ / _____ / _____ (M D Y) **#3** _____ / _____ / _____ (M D Y)

OR: ATTACH LABORATORY REPORT INDICATING POSITIVE VALUE OF IMMUNITY (Hepatitis B surface antibody)

B. REQUIREMENT FOR STUDENTS LIVING ON CAMPUS

MENINGOCOCCAL TETRAVALENT
Meningococcal Meningitis Vaccine given on or after 16th birthday, must include Groups A, C, Y, W-135.
BOOSTER DOSE REQUIRED IF GIVEN BEFORE 16th BIRTHDAY.

_____ / _____ / _____ (M D Y) **BOOSTER** _____ / _____ / _____ (M D Y)

C. REQUIREMENT FOR STUDENTS LIVING ON CAMPUS & ALL INTERNATIONAL STUDENTS

TUBERCULOSIS SCREENING
Within 6 months prior to entering school or moving into campus housing.

PPD/MANTOUX: Results: ☐ Negative ☐ Positive mm induration: _____ / _____ / _____ (M D Y)

If PPD is positive, Chest X-ray required: ☐ Normal ☐ Abnormal _____ / _____ / _____ (M D Y)
OR Quantiferon Gold Test required: _____ / _____ / _____ (M D Y) ☐ Negative ☐ Positive

Copy of Chest X-ray report and Quantiferon Gold lab results must be attached.

D. RECOMMENDED VACCINATIONS (not required)

TDAP (Tetanus/Diptheria/Pertussis) – 1 dose given after 2005 _____ / _____ / _____ (M D Y)

VARICELLA (Chicken Pox): **#1** _____ / _____ / _____ (M D Y) **#2** _____ / _____ / _____ (M D Y)

Your health care provider must complete this page and SIGN/STAMP below, OR you may attach acceptable evidence of vaccination to the form, i.e., copy of school or public health immunization record or a copy of your health care provider's record. All information must be in English.

Address: _____

Phone #: _____

_____
Physician/Health Care Provider Signature/Stamp