



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	Condition	Mother	Father	Sibling
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental/Emotional Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased (age____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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:

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

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; include 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 ____ / ____ / ____
OR Quantiferon Gold Test required: Negative Positive M D Y

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

D. RECOMMENDED VACCINATIONS (not required)

TDAP (Tetanus/Diphtheria/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