



## 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  
JULY 15<sup>th</sup>-FALL SEMESTER/ JANUARY 15<sup>th</sup>- SPRING SEMESTER

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 \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### 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<br>(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)

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**Allergies** (Please specify; include food, insect and environmental allergies.)

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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): \_\_\_\_\_

