



## 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  
Forms may also be faxed to: 732-987-2014

**ALL STUDENTS ARE REQUIRED TO COMPLETE THE STUDENT HEALTH FORM AND SUBMIT IT TO HEALTH SERVICES BEFORE JULY 15 FOR FALL SEMESTER AND JANUARY 15 FOR SPRING SEMESTER**

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

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Maiden/Former Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

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

Phone: (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_ (WORK) \_\_\_\_\_

Email \_\_\_\_\_

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 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

**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 NJ 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.

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.

**Meningococcal ACWY vaccine** can help protect against **meningococcal disease** caused by serogroups A, C, Y, and W-135 (Menactra and Menveo). A different meningococcal vaccine is available that can help protect against serogroup B (Bexsero and Trumenba). For more information refer to <https://www.cdc.gov/meningococcal> or contact your health care provider.

## 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: \_\_\_\_\_

## REQUIREMENT FOR ALL STUDENTS BORN ON OR AFTER 1/1/1957

1. 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

2. HEPATITIS B (3 doses of Hepatitis B vaccine, or 2 doses of adult vaccine in adolescents 11-15 years of age is required for all UNDERGRADUATE students enrolling with 12 or more credits, and for all GRADUATE students enrolling in 9 or more credits).

#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)

## REQUIREMENT FOR ALL FIRST TIME STUDENTS UNDER THE AGE OF 19 (Commuters & Residents) AND RESIDENT STUDENTS OVER THE AGE OF 19

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

\_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

BOOSTER: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

## 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:

Date Placed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y M D Y

If PPD is positive, Chest X-ray required: X-ray:  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. All results/reports must be submitted in English.*

## REQUIREMENT FOR ALL STUDENTS

COVID VACCINE (COMPLETED SERIES) AND BOOSTER DOSE

Dose #1: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2: \_\_\_\_/\_\_\_\_/\_\_\_\_ Manufacturer \_\_\_\_\_  
M D Y M D Y

Booster Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Manufacturer \_\_\_\_\_  
M D Y

## HIGHLY RECOMMENDED VACCINATIONS (16-23 years of age)

Discuss with your healthcare provider- Shared Clinical Decision Making

MENINGOCOCCAL B: (Bexsero) #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y M D Y

(Trumenba) #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y M D Y M D Y

RECOMMENDED VACCINATIONS

TDAP (Tetanus/Diphtheria/Pertussis) – 1 dose given after 2005 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

VARICELLA (Chicken Pox): #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y M D Y

YOUR HEALTH CARE PROVIDER MUST COMPLETE THIS PAGE & SIGN AND 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.

\_\_\_\_\_  
Physician/Health Care Provider Signature/Stamp

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_