STUDENT HEALTH & IMMUNIZATION RECORD

STUDENT HEALTH CENTER . CASTLE POINT ON HUDSON . HOBOKEN, NJ 07030 . 201-216-5678

TO THE STUDENT: This information is required of you to enable the College Health Service 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 ID# (UNDERGRADUATE STUDENTS LEAVE BLANK) _____

NAME _____ SEX: F ❑ M ❑
LAST FIRST MIDDLE

PERMANENT ADDRESS _____ TEL. NO. ( ) _____
NUMBER STREET

_____
CITY STATE ZIP CODE

CITIZENSHIP _____ EMAIL _____ CELL PHONE ( ) _____

AGE _____ DATE OF BIRTH _____ DATE ENTERING STEVENS _____
MONTH/YEAR

Undergraduate ❑ Graduate ❑ International ❑ Full Time ❑ Part Time ❑ Transfer ❑

Campus Resident (Living in campus owned housing) ❑ Commuter ❑

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____ ADDRESS: _____

HOME PHONE ( ) _____ WORK ( ) _____ CELL ( ) _____

INSURANCE INFORMATION

Note: If you DO NOT wish to purchase the student health insurance offered by Stevens, students must provide their insurance information online to University Health Plans at www.univhealthplans.com in order to waive the insurance premium. If students do not waive the insurance online, they will be responsible for the charges. PLEASE ATTACH A COPY OF ALL INSURANCE CARDS (front and back).

Name of Health & Hospitalization Insurance Company _____

Name of insured _____ Policy number _____

Coverage code (if any) _____ Group number (if any) _____

MEDICAL RELEASE

In case of routine health examinations, diagnostic procedure and treatment of illness and/or injuries, permission is hereby granted to treat the student named above at the Student Health Center 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 _____

Signature of Parent or Guardian _____ Date _____

(Signature of parent or Guardian is required for all students under 18 years of age)

❑ I authorize the Stevens Student Health Center to contact me by me email address for notification purposes.

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(s)
- ❑ Heart Problem/Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Infectious Mononucleosis
- ❑ Kidney Problems
- ❑ Learning Disability
- ❑ Lyme Disease
- ❑ Malaria
- ❑ Meningitis
- ❑ Migraine/Frequent Severe headaches
- ❑ Muscle Disorder
- ❑ Night Sweating
- ❑ Psychological/Emotional Issues
- ❑ 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 or pipe
  How many years _____
  How many a day _____

Do you now have or have you ever had :

❑ Incidents of self-harming behavior ❑ An abusive/controlling relationship ❑ Sleep difficulties

If yes, please comment _____

_____

Other medical conditions that you believe we should be aware of? (please explain) _____

_____

List any allergies: _____

Have you ever been hospitalized?_____ Had any operations? (please note details) _____

_____

List all current medications _____

List any serious injury _____

FAMILY HISTORY

	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 _____

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 Center 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.

REQUIRED

MMR (Combined Measles, Mumps, Rubella Vaccine) *Month/Day/Year* MMR #1 ____/____/____ MMR #2 ____/____/____
(2 doses required at least 28 days apart) *Dose 1 given at 12 months or later* *Dose 2 given at least 28 days after first dose*

MEASLES (Single Antigen Mumps Vaccine) *Month/Day/Year* #1 ____/____/____ #2 ____/____/____

MUMPS (single Antigen Mumps Vaccine) *Month/Day/Year* #1 ____/____/____ #2 ____/____/____

RUBELLA (Single Antigen Rubella Vaccine) *Month/Day/Year* #1 ____/____/____ #2 ____/____/____

❑ Born before 1957 and therefore considered immune.

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.

* MENINGITIS (Meningococcal Vaccine-covering serogroups A,C,Y, and W-135) We accept Menactra, Menomune or Menveo. If the initial dose was administered before the 16thbirthday, a booster dose should be administered after the 16th birthday. The minimum interval between doses of meningococcal conjugate vaccine is 8 weeks. #1 ____/____/____ #2 ____/____/____

HEPATITIS B VACCINE: Series of 3 doses #1 ____/____/____ #2 ____/____/____ `#3 ____/____/____

** PPD - Mantoux Test (Tuberculin skin test) - required for all students within the past 6 months, regardless of BCG history. PPD is invalid without signature by provider, and the date read.

Test Date: _____ Date Read: _____ Results: _____ mm

Lot #: _____ Exp. Date: _____ MFR: _____

Copy of chest x-ray required if > 10mm. induration (horizontal diameter).

INH prophylaxis taken? Yes _____ No_____ (If yes, please provide documentation.)

Prior PPD history: Date: _____ Results: _____ mm

* * Required by Stevens Institute of Technology

RECOMMENDED (OPTIONAL AT THE PRESENT TIME)

TETANUS/DIPHTHERIA: (within the last 10 years) ____/____/____

VARICELLA (Chicken Pox): ____/____/____ ____/____/____

FORMS WITHOUT SIGNATURES 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.

INFORMATION ON MENINGOCOCCAL DISEASE & VACCINATION

The New Jersey Department of Health and Senior Services (NJAC 8:57-6.6) requires that NJ colleges and universities provide incoming students with information about meningococcal disease and the meningococcal vaccine.

Meningococcal Disease Information
Please read the information below on Meningococcal Disease and respond to the following "I have received information about Meningococcal disease, the effectiveness of the vaccine, and the availability of the meningococcal vaccine."

❑ Yes ❑ No

Meningococcal Vaccine

❑ I will be residing on campus. I am therefore required by law and Stevens immunization policy to receive a meningococcal meningitis vaccine. At this time I have either received the vaccine (enter date on Immunization Record) or I plan to receive the vaccine prior to submission of this form.

❑ I will not be residing on campus, but I have already received the vaccine (enter date on Immunization Record), or I plan to have the vaccine at some future time.

❑ I will not be residing on campus and I have decided to not receive the meningococcal meningitis vaccine.

❑ I will not be residing in campus housing and I am undecided about receiving the meningococcal meningitis vaccine.

Student signature: _____ Date: _____

Parent/guardian signature *(if student is under 18 years of age)*: _____

New Jersey State Law requires that new students attending N.J. colleges and universities receive the Meningococcal Meningitis A, C, Y, W-135 vaccine prior to entering campus housing.

Meningitis is an infection of the spinal cord fluid and the fluid surrounding the brain. There are two major types of meningitis: The most common is viral meningitis, which can be caused by a variety of viruses. While viral meningitis may be a serious illness people usually recover completely in several days.

The other type, bacterial meningitis, is caused by several kinds of bacteria. The most serious is *Neisseria Meningitidis,* which cause Meningococcal meningitis. Meningococcal disease is the leading cause of bacterial blood stream infection and meningitis in children and young adults in the United States. Surveillance of Meningococcal disease among U.S. college students found a *modestly elevated rate of this disease among first-year students living in residence halls.* Data has also suggested that certain social behaviors such as, exposure to passive and active smoking, bar patronage and excessive alcohol consumption may increase students' risk for contracting the disease.

Though rare, the effects of Meningococcal disease can be devastating. Despite treatment with appropriate intravenous antibiotic and optimal medical care, the overall fatality rate of meningococcal meningitis is 9 to 12 percent, with a rate of up to 40 percent among patients with meningococcal blood stream infection. Eleven to 19 percent of survivors of meningococcal disease have permanent injury, such as hearing loss, neurologic disability, or loss of a limb.

One of the challenges of diagnosing Meningococcal disease is that its symptoms are difficult to distinguish from those of more common but less serious illnesses. Generally, symptoms include a sudden onset of headache, fever, and stiffness of the neck sometimes accompanies by nausea, vomiting, light sensitivity, confusion, or a purplish rash. *This illness can progress rapidly* with tragic consequences in a few hours unless appropriate intravenous antibiotic treatment is started shortly after the symptoms begin.

Most cases of Meningococcal disease occur sporadically or as individual cases without apparent connection to any case or person. Persons directly exposed to an infected person's oral secretions (i.e., kissing, mouth-to-mouth resuscitation) are at elevated risk for contracting the disease. Meningococcal bacteria is NOT spread through casual contact. Persons who have had close contact with the oral secretions of an infected person need post-exposure antibiotic therapy preferably within 48 hours to prevent the disease. This even includes those who have received the Meningococcal meningitis vaccine.

The best way to decrease the risk of Meningococcal disease is vaccination. Currently, there are two Meningococcal vaccines licensed and available in the U.S. The preferred Meningococcal vaccine is the CONJUGATE type (in the U.S. Menactra™ Sanofi Pasteur); however, the polysaccharide type of the vaccine (in the U.S., Menomune®, Sanofi Pasteur) is acceptable as long as vaccination occurred within 3 years of college entry. If not, a repeat vaccination must be obtained. Meningococcal vaccination is 85 to 100 percent effective against four of the five most common types of the bacteria that cause the disease. Studies show that up to 80 percent of cases of Meningococcal meningitis on college campuses are vaccine-preventable.

It is important for recipients of the Meningococcal vaccine to remember that no vaccine offers 100% protection. The Meningococcal vaccine consists of only 4 of the 5 most common types of Meningococcal disease. This means that the vaccine does not offer protection against all types of Meningococcal bacteria that cause this disease. In addition, not all cases of meningitis are caused by Meningococcal bacteria. Therefore, if symptoms of meningitis should develop, a vaccinated person should still seek medical attention.

Contact your healthcare provider for additional vaccine information, or call the Stevens Health Center at (201) 216-5678.

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 _____ SEX: F ❑ M ❑
LAST 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

RETURN ALL INFORMATION TO:

STUDENT HEALTH CENTER
STEVENS INSTITUTE OF TECHNOLOGY
1 CASTLE POINT ON HUDSON
HOBOKEN, NJ 07030

WEBSITES YOU SHOULD KNOW:

For information about the **Student Health Center**:
www.stevens.edu/health

For information about **Student Counseling Services**:
www.stevens.edu/counseling

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

PLEASE DISCUSS THIS FORM WITH YOUR PRIMARY CARE PROVIDER AND REMEMBER TO MAIL IT BACK TO:

STEVENS STUDENT HEALTH CENTER
1 CASTLE POINT ON HUDSON
HOBOKEN, NJ 07030

REMINDER!

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