STUDENT HEALTH & IMMUNIZATION RECORD

STUDENT HEALTH CENTER . CASTLE POINT ON HUDSON . HOBOKEN, NJ 07030 . T: 201-216-5678 . F: 201-216-5677

TO THE STUDENT: This information is required of you to enable the College Health Center 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_____ **GENDER**_____
LAST/FAMILY FIRST MIDDLE

PERMANENT ADDRESS_____
NUMBER STREET

_____**TEL. NO.** ( )_____
CITY STATE ZIP CODE

CITIZENSHIP_____ **STEVENS EMAIL** _____**CELL. NO.** ( )_____

AGE_____ **DATE OF BIRTH**_____**DATE ENTERING STEVENS**_____

Starting Semester Fall ❑ Spring ❑ Summer ❑ Year_____

CHECK ALL THAT APPLY:
Undergraduate ❑ Graduate ❑ International ❑ Domestic ❑ Full Time ❑ Part Time ❑ Transfer ❑

Campus Resident (Living on campus or leased housing) ❑ Commuter ❑

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME_____RELATIONSHIP_____ADDRESS_____

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

INSURANCE INFORMATION

STEVENS STUDENT HEALTH INSURANCE ❑ PRIVATE INSURANCE ❑ BOTH ❑

PLEASE ATTACH A COPY OF ALL INSURANCE CARDS (FRONT AND BACK)

CONSENT AND RELEASE

In case of diagnostic procedure and treatment of illness and/or injuries, permission is hereby granted to treat the student named below 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 in indicated.

SIGNATURE OF STUDENT_____DATE_____

***IF YOU ARE UNDER 18 YEARS OF AGE, SIGNATURE OF A PARENT/LEGAL GUARDIAN IS REQUIRED**

SIGNATURE OF PARENT/LEGAL GUARDIAN_____DATE_____

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

STUDENT NAME_____
STEVENS ID_____

REPORT OF MEDICAL HISTORY

Please complete this before going to your physician for examination.

PERSONAL HISTORY Do you know 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 or have you ever had:

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

If yes, please comment_____

_____

Other medical conditions, injuries, hospitalizations, or surgeries that you believe we should be aware of? (Please explain)_____

_____

List any allergies_____

List all current medications_____

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_____

STUDENT NAME_____
STEVENS ID_____

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 in Stevens owned or leased housing. 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 of Immunization Record) or plan to receive the vaccine prior to submission of this form.

- ❑ I will not be residing on campus or in Stevens leased housing, 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 or in Stevens leased housing and I have decided to not receive the meningococcal meningitis vaccine.

- ❑ I will not be residing in Stevens owned or leased housing and I am undecided about receiving the meningococcal meningitis vaccine.

Student signature:_____ Date:_____

***IF YOU ARE UNDER 18 YEARS OF AGE, SIGNATURE OF A PARENT/LEGAL GUARDIAN IS REQUIRED**

Signature of Parent/Legal Guardian:_____ Date:_____

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 State. Surveillance of Meningococcal disease among US 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 an 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 US. The preferred Meningococcal vaccine is the CONJUGATE type (in the US 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 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.

STUDENT NAME_____
STEVENS ID_____

IMMUNIZATION RECORDS

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* *(2 doses required at least 28 days apart)*	MMR#1___/___/___ *Dose 1 given at 12 months or later*	MMR#2___/___/___ *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.

VARICELLA (Chicken Pox) *Month/Day/Year*	#1___/___/___	#2___/___/___

Had Chicken Pox? Date: ___/___/___

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 16th birthday, 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___/___/___

*Only if living in Stevens owned or leased housing

STUDENT NAME_____
STEVENS ID_____

REQUIRED (continued)

****PPD – Mantoux OR Interferon-based Assay TB Blood Test (Quantiferon Gold or T-Spot)**

If Quantiferon Gold or T-Spot: (Must be performed within last year)

Result_____ (Attach copy of laboratory report)

If PPD-Mantoux Skin Test: (Must be performed within 6 months of entrance to Stevens)

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

Copy of chest x-ray required if: PPD is ≥ 10mm. induration (horizontal diameter) **OR** if Interferon-based Assay Blood Test is Positive

INH Therapy 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: ___/___/___ **OR** Tetanus/Diphtheria/Acelluar Pertussis (Tdap): ___/___/___
*(within 10 years)

HEPATITIS A (2 doses) ___/___/___ ___/___/___

FORMS WITHOUT SIGNATURE 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.

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 _____ GENDER_____
LAST/FAMILY 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	❑ Psychological	❑ Skin
❑ Metabolic/Endocrine	❑ Hernia	❑ Eyes
❑ Genitourinary	❑ Gastrointestinal	❑ Musculoskeletal
❑ Respiratory	❑ Neurological	❑ HEENT

(Physical Education, Intramurals) Explain: _____

_____

General Health: ❑ Excellent ❑ Good ❑ Fair ❑Poor

_____
Print Name

_____
Address

_____
Physician's Signature

_____
Office Stamp

Return all information by July 13, 2016:

Mail: Student Health Center
Stevens Institute of Technology
1 Castle Point on Hudson
Hoboken, NJ 07030

Email: studenthealthcenter@stevens.edu

Fax: 201-216-5677

PLEASE DISCUSS THIS FORM WITH YOUR PRIMARY CARE PROVIDER

Requirements Checklist:

❑ Copy of front and back of insurance card(s)

❑ Pages 1, 2, 3 must signed by student or parent/legal guardian if student is under 18 years of age

❑ Pages 4, 5, 6 must be completed in **English**, signed, and stamped by physician/healthcare provider

❑ Laboratory results (if needed as per the immunization records form)

UPON COMPLETION,
REMEMBER TO RETURN ALL INFORMATION:

Mail: Student Health Center
Stevens Institute of Technology
1 Castle Point on Hudson
Hoboken, NJ 07030

Email: studenthealthcenter@stevens.edu Fax: 201-216-5677

REMINDER!

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

Please check the website starting in July for the deadline and waiver.

WEBSITES YOU SHOULD KNOW:

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

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

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