

GEORGIAN COURT UNIVERSITY



Office of Health Services
900 Lakewood Ave.
Lakewood, NJ 08701-2697
732.987.2756
Fax: 732.987.2014
www.georgian.edu

STUDENT HEALTH FORM

Students WILL NOT be admitted to classes or residence halls without completed health form. ALL students must complete and return this form to the Office of Health Services.

Last Name	First Name	M.I.	Former Last Name(s)
Social Security Number		Birth Date	
Address		()	
City		Telephone - Home	
State	Zip	()	
		Telephone - Cell	

Please check box(es) which apply to you:

- Campus Resident (living on campus) Commuter (living in relative's or own home)
 Undergraduate Graduate Female Male

The semester you will begin attending Georgian Court: Fall Spring Summer _____ Year

Previous student at Georgian Court? Yes No When? _____

In case of emergency, please notify:

Name	Relationship	() Telephone	
Address	City	State	Zip

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.

CONSENT FOR TREATMENT

ALL STUDENTS

By signature, I verify that the information provided 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
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ALL 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
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FAMILY HISTORY (Please use the COMMENTS section if additional details are needed for clarification.)
Please check the appropriate box(es) if blood-related parent or sibling have 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 box(es) if you have a present or past history of

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Heart disease/problems | <input type="checkbox"/> Operations or serious injuries (list details below) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis/jaundice | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Psychological/emotional problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hospitalization (list details below) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intestinal/stomach trouble | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Kidney disease/bladder problems | <input type="checkbox"/> Sickle cell trait/anemia |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Disability/handicap | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Ear trouble/hearing loss | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Smoking/tobacco use |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Muscle, joint/bone disorder | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Eye disease/vision problems | | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Gallbladder trouble | | |
| <input type="checkbox"/> Head injury | | |

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 and over-the-counter medications.)

Medication	Dosage	Frequency
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Medication	Dosage	Frequency
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Medication	Dosage	Frequency
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Drug Allergies (Please specify.)

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

COMMENTS

MENINGITIS SURVEY

This survey MUST be completed by ALL students as required by New Jersey 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 at some future time.
(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.

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, and/or death can result from the infection. 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 appear to be at higher risk for the disease than college students overall.

Vaccination is an effective way for students to protect themselves against possible infection. The vaccine is 85 to 100 percent effective in preventing four strains of meningococcal disease, which together account for nearly 70 percent of meningococcal cases on campuses. The vaccine is safe, with mild and infrequent side effects. In the past, vaccination usually has been delayed until an outbreak of meningitis occurs. However, because outbreaks are clustered in time, and because onset of symptoms is extremely rapid, it makes sense for students to consider reducing their risk with a vaccination before an outbreak occurs.

It would be appropriate that students and parents consider, in consultation with their physician, receiving this vaccination prior to matriculating or returning to college. The meningitis vaccine is also available through the Office of Health Services; please call 732.987.2756 if you have any questions.

IMMUNIZATION RECORD
All information must be in English

Name _____

Date of Birth _____

REQUIRED VACCINATIONS

A. MEASLES, MUMPS, RUBELLA: All students born after 1956 (except non matriculating students).

MEASLES: TWO doses of live vaccine administered after 1968 and on or after first birthday
#1 ____/____/____ #2 ____/____/____
M D Y M D Y

MUMPS: ONE dose of live vaccine administered after 1968 and on or after first birthday
____/____/____
M D Y

RUBELLA: ONE dose of live vaccine administered on or after first birthday
____/____/____
M D Y

OR: MMR #1 ____/____/____ **#2** ____/____/____
M D Y M D Y

OR: ATTACH LABORATORY REPORT INDICATING IMMUNITY

B. HEPATITIS B: All students enrolling with 12 or more credits. Three doses of vaccine (or two doses of adult vaccine in adolescents 11-15 years of age).

#1 ____/____/____ #2 ____/____/____ #3 ____/____/____
M D Y M D Y M D Y

OR: ATTACH LABORATORY REPORT INDICATING IMMUNITY (Hepatitis B surface antibody)

C. MENINGOCOCCAL TETRAVALENT: Campus residents only.

____/____/____
M D Y

D. TUBERCULOSIS SCREENING: International and resident students only.

PPD (Mantoux) within the past 6 months: Results: Negative Positive mm induration ____/____/____
M D Y

If PPD is positive, chest x-ray required: X-ray: Normal Abnormal ____/____/____
M D Y

RECOMMENDED VACCINATIONS

TETANUS (Booster within last 10 years): ____/____/____
M D Y

VARICELLA: #1 ____/____/____ #2 ____/____/____
M D Y M D Y

ACCEPTABLE DOCUMENTATION INCLUDES:

1. A copy of school or public health immunization record.
2. A copy of a health care provider's record.
3. This section completed by a health care provider, with the provider's name, address, telephone number, and signature/stamp in the spaces provided below.

Physician or Health Care Provider Signature/Stamp

Address
(_____) _____
Telephone