GEORGIAN COURT UNIVERSITY
THE MERCY UNIVERSITY OF NEW JERSEY

Health Services
900 Lakewood Avenue
Lakewood, NJ 08701-2697
healthservices@georgian.edu

Tel: 732.987.2756
Fax: 732.987.2014
www.georgian.edu

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	☐	☐	☐	High Blood Pressure	☐	☐	☐
Asthma	☐	☐	☐	Kidney Disease	☐	☐	☐
Cancer	☐	☐	☐	Mental/Emotional Illness	☐	☐	☐
Deceased (age____)	☐	☐	☐	Stroke	☐	☐	☐
Diabetes	☐	☐	☐	Tuberculosis	☐	☐	☐
Heart Disease	☐	☐	☐				

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:

- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Disability/Handicap
- ☐ Ear Trouble/Hearing Loss
- ☐ Eating Disorder
- ☐ Eye Disease/Vision Problems
- ☐ Gallbladder Trouble
- ☐ Head Injury
- ☐ Heart Disease/Problems
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hospitalization (list details below)
- ☐ Intestinal/Stomach Trouble
- ☐ Kidney Disease/Bladder Problems
- ☐ Lyme Disease
- ☐ Menstrual Problems
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Muscle, Joint/Bone Disorder
- ☐ Operations or serious injuries (list details below)
- ☐ Pneumonia
- ☐ Paralysis
- ☐ Psychological/Emotional
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sickle Cell Trait/Anemia
- ☐ Sinus Trouble
- ☐ Skin Disorder
- ☐ Sleep Difficulties
- ☐ Smoking/Tobacco Use
- ☐ Thyroid Disease
- ☐ Tuberculosis

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)

____

____

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

____

____

☐ **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, W, and Y-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

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

_____/_____/_____ (M D Y) BOOSTER: _____/_____/_____ (M D Y)

REQUIREMENT FOR STUDENTS LIVING ON CAMPUS & ALL INTERNATIONAL STUDENTS

1. TUBERCULOSIS SCREENING (WITHIN 6 MONTHS PRIOR TO ENTERING SCHOOL OR MOVING INTO CAMPUS HOUSING.)

PPD/MANTOUX: **Results:** ☐ **Negative** ☐ **Positive** **mm induration:** _____/_____/_____ (M D Y)

If PPD is positive, Chest X-ray required: X-ray: ☐ **Normal** ☐ **Abnormal** _____/_____/_____ (M D Y)

OR Quantiferon Gold Test required: _____/_____/_____ (M D Y) ☐ **Negative** ☐ **Positive**

Copy of Chest X-ray report and Quantiferon Gold lab results must be attached. All results/reports must be submitted in English.

HIGHLY RECOMMENDED VACCINATIONS (16-23 years of age)

Discuss with your healthcare provider- Shared Clinical Decision Making

MENINGOCOCCAL B: (Bexsero) **#1** _____/_____/_____ (M D Y) **#2** _____/_____/_____ (M D Y)

(Trumenba) **#1** _____/_____/_____ (M D Y) **#2** _____/_____/_____ (M D Y) **#3** _____/_____/_____ (M D Y)

RECOMMENDED VACCINATIONS

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

VARICELLA (Chicken Pox): **#1** _____/_____/_____ (M D Y) **#2** _____/_____/_____ (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.

Address: ____________________________________

Phone #: ____________________________________

____

Physician/Health Care Provider Signature/Stamp