ENTRANCE HEALTH RECORD

• Immunization Record
• Meningitis Survey
• Medical History
• Physical Examination

This record must be fully completed and returned prior to registration to:

Saint Peter’s University
2641 Kennedy Boulevard
Jersey City, N.J. 07306
Attn: Health Services
ENTRANCE HEALTH RECORD

DIRECTIONS:
The Entrance Health Record must be completed and returned to the Office of Health Services. All medical information is confidential and will not be released without the students written authorization. However, in the event of a medical emergency only vital information will be released. Incomplete forms are not acceptable!

Status:  ❑ Undergraduate   ❑ Graduate   ❑ Transfer

Name:  ____________________________________________
Last       First       MI       Maiden/Former

ID/S.S. #: __________________________________________Date of Birth___/___/_____ Sex __________

Address: ________________________________________________________________________________
Street Address          City       State    Zip

Phone: ________________________________________________________________________________
Home           Work           Cell

PERSONS TO NOTIFY IN CASE OF EMERGENCY:
Name:  _____________________________________  Relationship: __________________________
Phone: ________________________________________________________________________________
Home           Work           Cell

Name:  _____________________________________  Relationship: __________________________
Phone: ________________________________________________________________________________
Home           Work           Cell

HEALTH/ HOSPITALIZATION INFORMATION:
Company_____________________________________   Name of Insured_______________________
Policy # ______________________________________

MEDICAL CONSENT AND RELEASE:
Permission is hereby given to perform routine health examination, provide preventative measures, medical treatment, first aid and referrals at Saint Peter’s University Office of Health Services. I also consent to the release of my medical records to appropriate health care providers in the event of an emergency.

Signature ____________________________________  Date _________________________________

Signature ____________________________________  Date _________________________________

Parent/ Guardian if student is under 18 years of age
SAINT PETER’S University
2641 Kennedy Boulevard, Jersey City, NJ 07306 • Phone# 201-761-7445 • Fax# 201-761-7447

Name:  ________________________________________________________________________________

    Last       First       MI       Maiden/Former

ID/S.S. #: __________________________________________Date of Birth___/___/_____ Sex __________

Address: ________________________________________________________________________________

    Street Address          City       State    Zip

Phone: ________________________________________________________________________________

    Home           Work           Cell

——— REQUIRED ———

MENINGITIS  Required for all Resident Students. Date of Vaccine:______________________________

PROOF OF IMMUNIZATIONS CONSISTS OF ONE OF THE FOLLOWING:
1. CERTIFICATE OF IMMUNIZATION SIGNED AND STAMPED BY PHYSICIAN.
2. SIGNED RECORD FROM SCHOOL, University OR PUBLIC HEALTH IMMUNIZATION OFFICE.
NOTE: ALL immunizations must be given after 1968 to be valid.

FIRST IMMUNIZATION
(Must be on or after 1st birthday)
MEASLES (Rubeola) _______________________
MUMPS_________________________________
GERMAN MEASLES________________________ (Rubella)
OR  _________________________________________
MMR #1 __________________________________       MMR#2 __________________________________

* If MMR vaccination records are not available, you may take a blood test (Titer) to prove immunity. A copy of the laboratory report is required. If Non-Immune, the state requires you to receive the appropriate vaccinations.

HEPATITIS B VACCINE  (Required for all who are registered for 12 or more credits.)
Dose #1 _____________________ Dose #2 _____________________ Dose #3 _____________________

*If Hepatitis B records are not available, you may take a blood test to prove immunity. A copy of the laboratory report is required. If Non-Immune, the state requires you to receive the appropriate vaccinations.

MENINGITIS SURVEY  For all Non-resident Students. Read survey on page 3 and circle one below.
A.) I have decided not to receive the Meningitis vaccine.
B.) I am undecided about whether to receive the Meningitis vaccine.
C.) I have decided to receive the Meningitis vaccine now or sometime in the future.

Signature ____________________________________  Date ________________________________

Signature ____________________________________  Date ________________________________

Parent/ Guardian if student is under 18 years of age

Physician’s Signature (OFFICE STAMP)____________________________________ Date __________

Address _________________________________________ Phone ________________________________
1.) MEASLES, MUMPS, AND RUBELLA REGULATIONS:
New Jersey State Law (N.J.A.C. 8:57:6.1.13) requires ALL University ENTRANTS to submit documented proof of immunization against Measles, Mumps and Rubella. (Prior to Registration)

MEASLES, MUMPS, AND RUBELLA REQUIREMENTS:
- TWO DOSES of a live Measles or Measles containing vaccine.
- ONE DOSE each of a live Mumps and Rubella vaccine.
  OR
- TWO DOSES of the combination vaccine Measles, Mumps, Rubella (MMR)
  OR
- BLOOD TEST (TITER) to verify immunity to Measles, Mumps, Rubella (lab results required)

**The first dose must be after the first birthday, second dose administered no less than one month later. If no childhood record is available then you must be vaccinated. The first and second dose given one month apart.

2.) HEPATITIS B REGULATIONS:
New Jersey State Law (N.J.A.C.8:57:6.9) requires (ALL FULL-TIME University ENTRANTS) to submit documented proof of immunization against Hepatitis B.
- Age: Born on or before January 1, 1957. Photocopy of birth certificate, driver’s license, or passport. (Required)
- Religious: Written statement explaining how these immunizations conflict with your beliefs. (Required)
- Medical: Physician’s written statement explaining exemption including diagnosis and due date if pregnant. (Required)

3.) MENINGITIS REGULATIONS:
NJ State Law A1546 requires all University Entrants who reside in a campus dormitory must receive a meningococcal vaccine as a condition of attendance.
Meningitis Requirements:
- A) Meningococcal Vaccine- Mandatory for all INCOMING RESIDENT students.
- B) Meningitis Survey-Mandatory, ALL students must complete and sign.

MENINGITIS SURVEY: (Please read the following info and complete survey on reverse page.)
Meningitis is an inflammation of the lining of the brain and spinal cord caused by either viruses or bacteria.

A) Viral Meningitis is more common than bacterial meningitis and usually occurs in late spring and early summer. Signs and symptoms of viral meningitis may include stiff neck, headache nausea vomiting and rash. Most cases of viral meningitis run a short, uneventful course. Persons who have had contact with an individual with viral meningitis do not require any treatment.

B.) Bacterial Meningitis occurs rarely and sporadically throughout the year, although outbreaks tend to occur in the late winter and early spring. Bacterial Meningitis in University –aged students is most likely caused by Neisseria meningitis or Streptococcus pneumonia. Common early symptoms include fever, severe sudden headache accompanied by mental changes, neck stiffness and rash. Because meningococcal meningitis can cause grave illness and rapidly progresses to death, it requires early diagnosis and treatment. It is a vaccine preventable illness.

MENINGITIS EXEMPTION:
Religious: Written statement with bonifide religious tenets as to why vaccine cannot be administered. Philosophical or Moral objections are not sufficient.
Medical: Written statement by a licensed physician explaining why vaccine is contraindicated
PERSONAL HISTORY
Please check if you have had any of the following:
- Anemia
- Arthritis
- Asthma
- Alcohol abuse
- Back problems
- Bronchitis
- Cancer
- Chronic fatigue
- Diabetes
- Eating disorder
- Emphysema
- Epilepsy
- Fainting spells
- Frequent cough
- Glasses/contact lenses
- Head injury/concussion
- Hearing aid
- Heart Problem/murmur
- Hepatitis
- High blood pressure
- Infectious mononucleosis
- Kidney problems
- Lyme disease
- Malaria
- Meningitis
- Migraine/severe headaches
- Muscle disorder
- Night sweating
- Neurological disorder
- Rheumatic fever
- Recent weight gain/loss
- Sinusitis
- Skin disorder
- Tonsillitis
- Tuberculosis
- Unexplained aches and pains
- Wheezing
- Smoke cigarettes, cigar, or pipe

Current medications______________________________________________
Allergies to medications__________________________________________

FAMILY HISTORY
(If deceased, please list age and cause of death)

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
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<tr>
<td>Sibling</td>
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<tr>
<td>Sibling</td>
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</tr>
</tbody>
</table>

(Add more siblings as necessary)

Has any of your immediate family ever had any of the following (Please state relationships):
- Tuberculosis__________________________________________________
- Diabetes_____________________________________________________
- Cancer_______________________________________________________
- Heart Disease________________________________________________
- High Blood Pressure___________________________________________
- Kidney Disease_______________________________________________
- Other________________________________________________________

PHYSICAL EXAMINATION (To be completed by Physician)

Name of Patient__________________________________________________

Height ______ Weight ______ B/P ______ Pulse ______

Assessment:

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Skin</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Head, Neck</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Ear, Nose, Throat</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Eyes</td>
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<td>□</td>
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<tr>
<td>5. Heart</td>
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<td>□</td>
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<tr>
<td>6. Lungs, Chest</td>
<td>□</td>
<td>□</td>
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<tr>
<td>7. Abdomen &amp; Viscera</td>
<td>□</td>
<td>□</td>
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<tr>
<td>8. Neurological</td>
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<td>□</td>
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<tr>
<td>9. Genitalia, Hernia</td>
<td>□</td>
<td>□</td>
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<tr>
<td>10. Musculoskeletal:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Spine</td>
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<td>□</td>
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<tr>
<td>Upper extremities</td>
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<td>□</td>
</tr>
<tr>
<td>Lower extremities</td>
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</tbody>
</table>

Abnormal findings:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Comments/Recommendations:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Physician’s Signature/ Office Stamp ______________________ Date________