ENTRANCE HEALTH RECORD

- Demographics
- Immunization Records
- Immunization Regulations
- Personal Medical History
- Physical Exam

DIRECTIONS: PLEASE CAREFULLY READ AND COMPLETE THE ENTIRE FORM. Students must complete the demographics and personal medical history portions. The physician must complete the Immunizations and physical exam portion. Signed Immunization records from your physician, the state, high school, or previous college/university are accepted and may be attached to the packet if available.

THE ENTRANCE HEALTH RECORD MUST BE COMPLETED AND RETURNED ONLY TO THE OFFICE OF HEALTH SERVICES. INCOMPLETE FORMS ARE NOT ACCEPTABLE!

Students who fail to comply, WILL NOT be able to register for a second semester.

THIS RECORD MUST BE FULLY COMPLETED AND RETURNED PRIOR TO CHECK-IN (for residents) AND PRIOR TO THE START OF THE SEMESTER (for commuters).

Records must be submitted ONLY to The Office of Health Services through mail, email, or fax.

All medical and immunization information is kept confidential and will not be released without the student’s written authorization. However, in the event of medical emergency only vital information will be released.

The Office of Health Services
1st Fl. Saint Peter Hall
p: 201-761-7445
f: 201-761-7447
e: healthservices@saintpeters.edu
Status: ☐ Undergraduate ☐ Graduate Transfer: ☐ Yes ☐ No
Starting Semester: ☐ Fall ☐ Spring Academic Year: ___________
Housing Status: ☐ Resident ☐ Commuter

Name: ____________________________________________________________________________________
    Last     First    MI    Maiden/Former
ID or 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:
Do you have health insurance? _____Yes _____No If yes, please indicate the following:
Insurance Company ________________________________ Name of Insured _________________________
Policy # _________________________________________

MEDICAL CONSENT AND RELEASE:
Permission is hereby given to perform routine health examinations, 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 the appropriate health care providers in the event of an emergency.

Signature _______________________________________________ Date ______________________________
Signature _______________________________________________ Date ______________________________
Parent/Guardian Signature required if student is under 18 years of age.
—— REQUIRED IMMUNIZATIONS ———

(SEE IMMUNIZATION REGULATIONS FOR MORE INFORMATION)

Proof of Immunizations Consist 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.
3. Lab Work (Titer) Showing Immunity.

MENINGITIS A REQUIREMENTS:
(REQUIRED FOR ALL STUDENTS UNDER THE AGE OF 31)
Date of Vaccine: ____________________________
* NOTE: DATE OF MENINGITIS A VACCINE MUST BE WITHIN THE PAST 5 YEARS.

MMR (Measles, Mumps, Rubella) VACCINE REQUIREMENTS:
FIRST IMMUNIZATION                                SECOND IMMUNIZATION
(Must be on or after 1" birthday)                 (Must be 30 days after 1" dose)
MEASLES (Rubeola) ______________________________ MEASLES (Rubeola) ________________
MUMPS __________________________________________
RUBELLA (German Measles) ________________

OR

MMR #1 __________________________________________ MMR #2 __________________________
*If MMR vaccination records are not available, lab work (Titer) is required to prove immunity. Laboratory results must be submitted; if NON-IMMUNE, the state requires you to receive the appropriate vaccinations.

HEPATITIS B VACCINE REQUIREMENTS:
(Required for all who are registered for 12 or more credits)

Dose #1 ________________  Dose #2 ________________  Dose #3 __________________________
*If Hepatitis B vaccination records are not available, lab work (Titer) is required to prove immunity. Laboratory results must be submitted; if NON-IMMUNE, the state requires you to receive the appropriate vaccinations.

Physician’s Signature (Office Stamp) ____________________________ Date: ________________

Address: __________________________________________ Phone: __________________________
IMMUNIZATION REGULATIONS, REQUIREMENTS & EXEMPTIONS
PLEASE READ CAREFULLY!

Measles, Mumps, 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
- LAB WORK (TITER) to verify immunity of Measles, Mumps, Rubella (lab results required)

**The first dose must be administered after your first birthday; second dose must be administered no less than one month later. If no childhood record is available then you must be vaccinated.

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.

Hepatitis B Requirements:
- THREE DOSES of Hepatitis B vaccine
  OR
- LAB WORK (TITER) to verify immunity of Hepatitis B (lab results required)

**The first and second dose should be administered one month apart. The third does should be administered four to six months after the second dose. If no childhood record is available you must be vaccinated.


This law requires ALL UNIVERSITY ENTRANTS UNDER AGE 31 to submit documented proof of immunization against Meningitis A.

Meningitis (Meningococcal conjugate MenACWY, Menactra, Menevo) Requirements:
1. Meningococcal A Vaccine - Mandatory for all (undergraduate, graduate, full-time and part-time) INCOMING students under the age of 31.

Meningitis is an inflammation of the lining of the brain and spinal cord caused by either viruses or bacteria.

- **Viral Meningitis** usually occurs in late spring and early summer. Signs and symptoms may include stiff neck, headache, nausea, vomiting, and rash. Most cases run a short, uneventful course. Persons who have had contact with an individual with viral meningitis do not require any treatment.
- **Bacterial Meningitis** occurs rarely and sporadically throughout the year. In college–aged students it 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 progress to death, it requires early diagnosis and treatment. It is a vaccine preventable illness.

EXEMPTIONS

Measles, Mumps, and Rubella, Hepatitis B and Meningitis A Exemptions:
- Age – Those over the age of 31 are not required to submit records.
- Religious - Written statement with bona fide tenets as to why vaccine cannot be administered. Philosophical or Moral objections are not sufficient.
- Medical –Written statement by licensed Physician explaining why vaccine is contraindicated.
Saint Peter's University  Office of Health Services  Entrance Health Record

PERSONAL MEDICAL HISTORY (Please check if you have or have had any of the following)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid Reflux</td>
<td>Fainting Spells</td>
<td>Migraines</td>
</tr>
<tr>
<td>Anemia</td>
<td>Glasses/Contact Lens</td>
<td>Recent weight gain/loss</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Head Injury/Concussion</td>
<td>If so, how much __________?</td>
</tr>
<tr>
<td>Asthma</td>
<td>Hearing/Speech Deficit</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>Alcohol or Substance Abuse</td>
<td>Heart Problem/Murmur</td>
<td>Skin Disorder</td>
</tr>
<tr>
<td>Blood Disorder</td>
<td>HIV/AIDS</td>
<td>Smoker Pks/day? __________</td>
</tr>
<tr>
<td>Cancer</td>
<td>Hepatitis</td>
<td>Tonsillitis (Chronic)</td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td>High Blood Pressure</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Infectious Mononucleosis</td>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>Depression</td>
<td>Kidney Problems</td>
<td>OTHER:</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>Lyme Disease</td>
<td></td>
</tr>
<tr>
<td>Seasonal Allergies</td>
<td>Meningitis</td>
<td></td>
</tr>
</tbody>
</table>

If you have checked any of the above, please provide a brief explanation.

__________________________________________________________________________________________
__________________________________________________________________________________________

Hospitalizations and/or surgeries: (please specify type and year)

__________________________________________________________________________________________

Series injuries and/or persistent medical problems:

__________________________________________________________________________________________
__________________________________________________________________________________________

Allergies: (to medications and/or foods)

__________________________________________________________________________________________
__________________________________________________________________________________________

Family History

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>Health Status (please list if there are any severe medical problems present)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recommended Physical Examination (to be completed by Physician)

Name of Patient: ________________________________________________

Height: _______  Weight: _______  B/P: _______  Pulse: _______

<table>
<thead>
<tr>
<th>Part (Organ)</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Abnormal Findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Head/Neck</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Ear, Nose, Throat</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>O</td>
<td>O</td>
<td>Comments/Recommendations:</td>
</tr>
<tr>
<td>Lungs, Chest</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Abdomen &amp; Viscera</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Genitalia, Hernia</td>
<td>O</td>
<td>O</td>
<td>Physician’s Signature/Office Stamp</td>
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<tr>
<td>Musculoskeletal</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>