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

——DEMOGRAPHICS——

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———

TO BE COMPLETED BY PHYSICIAN

(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

(Must be on or after 1st birthday)

MEASLES (Rubeola) _____

MUMPS _____

RUBELLA (German Measles) _____

SECOND IMMUNIZATION

(Must be 30 days after 1st dose)

MEASLES (Rubeola) _____

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 –T IME 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.**

Meningitis Regulations

New Jersey State Law P.L. 2019, c332 amends P.L. 2003, c.284 (N.J.S.A. 18A:62-15.1) takes effect June 15, 2020. This law requires **ALL UNIVERSITY ENTRANTS UNDER AGE 31** to submit documented proof of immunization against Meningitis A.

Meningitis (Meningococcal conjugate MenACWY, Menactra, Menveo) 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.

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

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

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

Family Member:	Age	Health Status (please list if there are any severe medical problems present)
Father		
Mother		
Siblings		

Recommended Physical Examination (to be completed by Physician)

Name of Patient: _____

Height: _____ **Weight:** _____ **B/P:** _____ **Pulse:** _____

	Normal	Abnormal
Skin	O	O
Head/Neck	O	O
Ear, Nose, Throat	O	O
Eyes	O	O
Heart	O	O
Lungs, Chest	O	O
Abdomen & Viscera	O	O
Neurological	O	O
Genitalia, Hernia	O	O
Musculoskeletal	O	O

Abnormal Findings:

_____

_____

_____

Comments/Recommendations:

_____

_____

_____

Physician's Signature/Office Stamp

_____Date_____