



## **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 College  
2641 Kennedy Boulevard  
Jersey City, N.J. 07306  
Attn: Health Services

THE JESUIT COLLEGE OF NEW JERSEY

**EDUCATION. ONE STUDENT AT A TIME.**

# 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 College 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 COLLEGE

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, COLLEGE 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) \_\_\_\_\_

MMR #1 \_\_\_\_\_

### SECOND IMMUNIZATION

*(Must be 30 days after first dose)*

MEASLES (Rubeola) \_\_\_\_\_

OR \_\_\_\_\_

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 \_\_\_\_\_

# **IMMUNIZATIONS REGULATIONS & REQUIREMENTS**

**(PLEASE READ CAREFULLY)!**

**REVERSE PAGE MUST BE COMPLETED AND RETURNED PRIOR TO REGISTRATION.**

## **1.) MEASLES, MUMPS, AND RUBELLA REGULATIONS:**

New Jersey State Law (N.J.A.C. 8:57:6.1.13) requires ALL COLLEGE 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 COLLEGE 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 College 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 college –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 \_\_\_\_\_

## PHYSICAL EXAMINATION (To be completed by Physician)

Name of Patient \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_ Pulse \_\_\_\_\_

### Assessment:

	Normal	Abnormal
1. Skin	<input type="checkbox"/>	<input type="checkbox"/>
2. Head, Neck	<input type="checkbox"/>	<input type="checkbox"/>
3. Ear, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>
4. Eyes	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart	<input type="checkbox"/>	<input type="checkbox"/>
6. Lungs, Chest	<input type="checkbox"/>	<input type="checkbox"/>
7. Abdomen & Viscera	<input type="checkbox"/>	<input type="checkbox"/>
8. Neurological	<input type="checkbox"/>	<input type="checkbox"/>
9. Genitalia, Hernia	<input type="checkbox"/>	<input type="checkbox"/>
10. Musculoskeletal:		
Spine	<input type="checkbox"/>	<input type="checkbox"/>
Upper extremities	<input type="checkbox"/>	<input type="checkbox"/>
Lower extremities	<input type="checkbox"/>	<input type="checkbox"/>

### Abnormal findings:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Comments/Recommendations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Physician's Signature/ Office Stamp

\_\_\_\_\_ Date \_\_\_\_\_

## FAMILY HISTORY

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

	Age	Health Status
Father	_____	_____
Mother	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Sibling	_____	_____

(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 \_\_\_\_\_