

**Please fill out all the enclosed health forms, including the needed signatures, and return by July 15 for Fall admission, December 15 for Spring admission and April 15 for Summer admission.**

If you are taking 12 or more credits any semester, you are required to have documentation of Hepatitis B vaccination. If you are a matriculated student, you must complete the following requirements. If you are unsure of your status, please contact the Registrar at 856-256-4350. Failure to complete these requirements will result in an **Immunization Hold** placed on your student record. This **“hold”** will prevent you from registering for courses or receiving grades. We are in the process of making forms available online. Please visit our website to see if the online process is available.

**Send all forms to:**

Rowan University • Student Health Center • Linden Hall • 201 Mullica Hill Road • Glassboro, NJ 08028-1701  
856.256.4333 (phone) • 856.256.4427 (fax) • [www.rowan.edu/health](http://www.rowan.edu/health)

*Required Personal Health/History Form*

*Required Immunization Form*

- MMR Vaccinations (2)** — In lieu of vaccination, you may submit positive laboratory titer report for Measles, Mumps and Rubella.
- Hepatitis B Vaccinations (series of 3)** (for students taking 12 or more credits)
- Meningococcal Vaccinations** (Menactra®) for intercollegiate athletes and students residing in campus housing

*Required Tuberculosis Screening Form*

Please complete and return the TB screening form. **Anyone high risk for TB must have a Mantoux test (PPD skin test).** Anyone with a history of a positive Mantoux should submit chest x-ray with radiologist report and physician report of treatment history.

*Required Meningitis Information & Response Form*

*Proof of Health Insurance Requirement*

All full-time matriculated undergraduate and graduate students are required by NJ law to have health insurance coverage. All full-time matriculated students will be automatically enrolled in and billed for the University plan. In order to avoid compulsory enrollment under the University plan, students covered by other adequate insurance must complete an online Insurance Waiver Form indicating this coverage.

To complete the waiver process, go to [www.rowan.edu/bursar](http://www.rowan.edu/bursar) and click on “Student Health insurance Waiver.” Follow the instructions given to waive coverage and print a receipt for your records. You must complete this process prior to the end of drop/add week. If you have any questions about the online waiver or the health insurance fee, please call the Bursar’s Office at 856-256-4150.

If you have questions about the health insurance coverage, please visit [www.firststudent.com](http://www.firststudent.com) or the Student Health Center website at [www.rowan.edu/health](http://www.rowan.edu/health).

All required immunizations and tests are offered for a fee to incoming students at the Student Health Center.

# Personal Health Information & Consent for Treatment

- Graduate
- Post-Baccalaureate
- Graduate Certificate
- CPCE

## PERSONAL INFORMATION

Name \_\_\_\_\_ Entrance date \_\_\_\_\_  
Last First Middle

Email \_\_\_\_\_ Rowan ID # \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number (home) \_\_\_\_\_ Cell number \_\_\_\_\_ Parents'/spouse business phone \_\_\_\_\_

In case of emergency, please contact: \_\_\_\_\_  
Name \_\_\_\_\_

Day \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_  
phone phone

## CONSENT FOR TREATMENT

I hereby authorize the Rowan University Student Health Center staff and physicians to provide health care evaluations, treatment and other medical services as necessary and certify, to the best of my knowledge, that the information provided in my health record is complete and accurate.

In case of emergency, I authorize the Student Health Center to secure emergency medical treatment and/or surgery at a hospital if such treatment is deemed necessary. I authorize the Rowan University Student Health Center staff and physicians to share medical information with hospital or emergency medical personnel in the case of an emergency and subsequent treatment.

I understand that Health Center staff and affiliated health care providers, including counseling and psychological services staff, retain the privilege to consult with one another about clients for treatment and/or training purposes. If you participate in group counseling or health education, as a member of that group, you will be expected to commit to maintaining the confidentiality of that group.

This authorization will remain in effect as long as I am a student at Rowan University. I understand that in the event of serious illness or injury, my parents or legal guardian may be notified at the discretion of the Student Health Center staff. All health and personal information is confidential. Any release of your personal and health information requires a signed consent to release the requested information.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or guardian signature (for students under 18 years of age) \_\_\_\_\_ Date \_\_\_\_\_

## FAMILY MEDICAL HISTORY

Please list family members who have had any of the following:

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

High blood pressure \_\_\_\_\_

Kidney disease \_\_\_\_\_

Psychiatric disorder \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Heart problems \_\_\_\_\_

Died suddenly before age 50 \_\_\_\_\_

Fainting or seizures \_\_\_\_\_

Name \_\_\_\_\_  
 Last \_\_\_\_\_ First \_\_\_\_\_ Date of birth \_\_\_\_\_

### PERSONAL HISTORY

	NO	YES If yes, please explain
Are you allergic to any medications?		
Do you have any allergies to foods, dyes, bees or other insect bites?		
Do you have any seasonal allergies ("hay fever")?		
Have you ever had any medical problems?		
Do you have any chronic condition? (diabetes, asthma, depression, sickle cell, etc.)		
Have you ever been denied participation in sports?		
Have you ever been hospitalized?		
Have you ever had surgery?		
Have you ever had a prolonged unexplained viral illness either in the past or recently?		
Have you ever had any disability, limitation of motion or deformities?		
Do you require any accommodations for the above in the classroom or residence hall?		
Are you presently taking any medications or pills?		
Have you ever passed out during or after exercise?		
Have you ever had chest pain during or after exercise?		
Do you tire more quickly than your friends during exercise?		
Have you ever had high blood pressure?		
Have you ever been told that you have a heart murmur?		
Have you ever had racing of your heart or skipped heartbeat?		
Do you have any skin problems? (itching, rashes, acne, etc.)		
Have you ever had a head injury?		
Have you ever been knocked out or unconscious?		
Have you ever had a seizure?		
Have you ever had a stinger, burner or pinched nerve?		
Have you ever had heat or muscle cramps?		
Have you ever been dizzy or passed out in the heat?		
Do you have trouble breathing or do you cough during or after activity?		
Do you use any special equipment? (pads, braces, neck rolls, mouth guard, eye guards, etc.)		
Have you ever had any problems with your eyes or vision?		
Do you wear glasses or contacts or protective eye wear?		
Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? <input type="checkbox"/> head <input type="checkbox"/> neck <input type="checkbox"/> shoulder <input type="checkbox"/> chest <input type="checkbox"/> back <input type="checkbox"/> hip <input type="checkbox"/> elbow <input type="checkbox"/> forearm <input type="checkbox"/> wrist <input type="checkbox"/> hand <input type="checkbox"/> thigh <input type="checkbox"/> shin <input type="checkbox"/> calf <input type="checkbox"/> ankle <input type="checkbox"/> foot <input type="checkbox"/> knee		
Have you had a medical problem or injury since your last medical evaluation?		
Have you used alcohol, marijuana, or other "street" or recreational drugs in the past year?		
Do you feel stressed out?		
Do you feel you need extra support to deal with your stress?		
Are you dissatisfied with your eating patterns?		
Have you restricted your food intake due to concerns about your weight or body size?		
Have you used binge eating, purging, laxatives or diuretics as a means of weight control?		
Women only: When was your first menstrual period? _____ Age? _____ What was the longest time between your periods last year? _____		

Please return completed medical records, immunization record and meningitis survey response to the Student Health Center.

# IMMUNIZATION RECORD

*This form must be signed by a physician or nurse practitioner. Dates must include month/day/year.  
(Immunization Record must be submitted BEFORE your first semester.)*

Student name _____	_____	_____	_____	_____
Last	First	Middle	/	Date of birth

**Required (2) MMR Vaccinations:** All students born AFTER 1956 must have immunization against measles, mumps and rubella (2 MMRs) given after 1968, and ON or AFTER 12 months of age. **[NJ State law (N.J.A.C. 8:57-6.3)]**

MMR (two doses at least 30 days apart)		Measles #1 _____	#2 _____
#1 _____		Mumps #1 _____	#2 _____
#2 _____	<b>OR</b>	Rubella #1 _____	#2 _____

**Required Hepatitis B Vaccination (series of 3):**

Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**Required Meningococcal (tetraivalent A,C,Y,W-135) Vaccination:** All students residing in campus housing and intercollegiate athletes must show proof of meningococcal vaccination. ***This vaccine is highly recommended for all students.***

Meningococcal vaccine (Menactra®) \_\_\_\_\_

**Highly Recommended:** (Tetanus and Hepatitis B series **required** for intercollegiate athletes, cheerleading students)

Tetanus (Td or TT or TdaP) Booster in last 10 years \_\_\_\_\_

Varicella #1 \_\_\_\_\_ #2 \_\_\_\_\_

Hepatitis A #1 \_\_\_\_\_ #2 \_\_\_\_\_

Inactivated Polio Vaccine (IPV) Booster \_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician/Nurse Practitioner** (required to be valid)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Phone**

## EXEMPTIONS\*

- Age** Born in or before 1956 (MMR only). Birth date: \_\_\_\_\_
- Religious** To claim a religious exemption, you must by NJ State law "submit a written statement explaining how the administration of immunizing agents conflicts with" your belief. **Please use a separate paper to write this statement** and include a reference or quote that supports your request. **You must sign the statement** before mailing it back to the Student Health Center.
- Medical** (Valid contraindication to vaccine administration. Must be for a specific time period, signed by a physician/nurse practitioner and subject to periodic review.)

Physician/Nurse Practitioner statement: \_\_\_\_\_

Length of Exemption: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician/Nurse Practitioner**

\_\_\_\_\_  
**Date**

*\*In the event of a vaccine preventable disease outbreak, the University may exclude students with exemptions from classes or institution-sponsored activities.*

# Tuberculosis (TB) Screening & Symptom Assessment Form

Student name \_\_\_\_\_

Date of birth \_\_\_\_\_

Today's date \_\_\_\_\_

## *Please answer the following questions:*

- No     Yes    Do you have a productive, prolonged cough that has lasted for more than three weeks?
- No     Yes    Are you coughing up any blood?

*These are the primary symptoms of pulmonary TB. If either of the above symptoms is reported, a chest radiograph is warranted regardless of the results of a Mantoux tuberculin skin test.*

## *Do you have any of the following?* (Please check all of the following that apply)

- No     Yes    Unexplained weight loss (10 pounds or more without dieting)
- No     Yes    Night sweats (regardless of room temperature)
- No     Yes    Unexplained loss of appetite
- No     Yes    Very easily tired (fatigability)
- No     Yes    Fever
- No     Yes    Chills
- No     Yes    Chest pain

## *Other screening questions:*

- No     Yes    Have you ever resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS or homeless shelters, or injected drugs?
- No     Yes    Do you have any condition such as diabetes, HIV, chronic renal failure, leukemia or lymphoma, low body weight (10% below ideal), gastrectomy and jejunioileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (eg., Prednisone 15 mg daily for one month or more) or other immunosuppressive disorders?
- No     Yes    Within the past five years, have you stayed for more than three months in countries **OTHER THAN** the following:
- |                |               |                     |                      |
|----------------|---------------|---------------------|----------------------|
| American Samoa | Germany       | Malta               | San Marino           |
| Australia      | Greece        | Monaco              | Sweden               |
| Belgium        | Iceland       | Netherlands         | Switzerland          |
| Canada         | Italy         | New Zealand         | United Kingdom       |
| Denmark        | Jamaica       | Norway              | United States        |
| Finland        | Liechtenstein | St. Kitts and Nevis | Virgin Islands (USA) |
| France         | Luxembourg    | St. Lucia           |                      |
- No     Yes    Have you been in close contact with a person with Tuberculosis?

◆ If you have checked **YES** for any of the above questions you are **HIGH RISK** for Tuberculosis and you are **REQUIRED** to have a Mantoux test.

◆ If you have had a positive Mantoux (PPD) test ( $\geq 10$  mm in duration) **DO NOT** get another Mantoux test. Instead, you **MUST** get a chest x-ray and submit the radiologist report to us.

# Meningitis Information & Response Form

By N.J. State law, every incoming student must be given information about Meningitis and the availability of a vaccine to prevent a bacterial type called Meningococcal Meningitis. All incoming students must complete and return this survey to the Student Health Center.

## ◆ Definition and Causes

Meningitis is an inflammation of the lining of the brain and spinal cord caused by either viruses or bacteria. It is spread by direct contact (such as sharing a glass) with infected individuals.

## ◆ Nature & Severity

*Viral meningitis* is more common than bacterial meningitis, and usually occurs in late spring and early summer. Signs and symptoms of viral meningitis include stiff neck, headache, nausea, vomiting and rash.

*Bacterial meningitis* occurs rarely and throughout the year, although outbreaks tend to occur in late winter and early spring. Bacterial meningitis in college-aged students is most likely caused by *Neisseria Meningitidis* (meningococcal meningitis) or *Streptococcus Pnuemoniae*. Common 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. In contrast to viral meningitis, persons who have had close contact with someone infected will require preventive antibiotic treatment.

## ◆ Incidence

About 2,600 people get meningococcal disease each year in the U.S. and 10-15% of these people die in spite of treatment with antibiotics. College students are more susceptible to meningitis because they live and work in close proximity to others. Also, certain activities such as smoking, alcohol consumption and "clubbing" are associated with an increased susceptibility to contracting meningitis.

## ◆ Prevention

Meningococcal (tetraivalent A,C,Y,W-135) vaccine (Menactra®) can provide protection from 4 out of 5 strains of the *Neisseria Meningitidis*. Protection from the Menomune® vaccine lasts at least 3-5 years. The newer Menactra® vaccine is thought to provide immunity lasting 10 or more years. Students should also practice good hand washing, and avoid sharing food, drinks and cigarettes.

## ◆ Availability

Contact your health care provider or the Rowan University Student Health Center for further information about the availability of the vaccine. The meningitis vaccine is available at the Student Health Center for a fee.

## *Meningitis Survey Response Form*

*This survey shall become part of the student's health record as required by N.J. Law, P.L.2000c.25.*

I have read the above information about Meningitis, the effectiveness of the vaccine for meningococcal meningitis and the availability of a meningitis vaccine.

**I understand that the meningitis vaccine is required prior to living in campus housing.**

### Check one below:

- I have decided to receive the meningitis vaccine now or at some future time.
- I have decided not to receive the vaccine and I will not be living in campus housing.
- I am undecided about whether or not to receive the meningitis vaccine and I will NOT be living in campus housing.
- I have received the meningitis vaccine. (Must show proof of Menomune® or Menactra® vaccine on Immunization Records)

\_\_\_\_\_  
Student Name (print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Rowan ID #

\_\_\_\_\_  
Signature  
(Student or Parent/Guardian if student is under 18 years of age)

\_\_\_\_\_  
Date