

Personal Information & Consent for Treatment

Name _____ Entrance Date _____
Last First Middle

Email _____ Rowan ID # _____ Date of Birth _____

Address _____
Street Apt. #
City State Zip

Phone Number _____
Home Cell Phone Parents'/Spouse business phone

In case of emergency please contact: _____
Name Relationship

Day Phone Evening Phone Cell Phone

Consent for Treatment

I hereby authorize 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 Rowan University Student Health Center staff and physicians to share any medical information with hospital or emergency medical personnel in the case of an emergency or subsequent treatment.

I understand that the 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.

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

Date

Family Medical History

Please list any 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 and seizures _____

Personal Health History

Last Name _____

First Name _____

M.I. _____

Date of Birth _____

	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?		
Have you ever had 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?		
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? (Please specify type of injury and body part that was injured.)		
Have you had a medical problem or injury since your last medical evaluation?		
Do you drink alcohol?		
Have you used marijuana, 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 ever 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? _____		
Health Insurance Information: Name & Type of Policy (ex: Horizon – HMO) _____ ID # _____ Group # _____ Insurance company Address _____ Name of Insured and Relationship _____		

Tuberculosis (TB) Screening Form

Student Name _____

Rowan ID # _____

YES NO

Have you ever had a positive tuberculosis skin test or blood test?

Have you ever had close contact with anyone who was sick with TB?

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years?

Have you ever stayed more than 3 months in one of the countries listed below?

Have you ever been vaccinated with BCG

Afghanistan	Algeria	Comoros	Haiti	Mali	Philippines	Tajikistan
Angola	Anguilla	Congo	Honduras	Marshall Islands	Poland	Tanzania-UR
Argentina	Armenia	Congo DR	India	Mauritania	Portugal	Thailand
Azerbaijan		Cote d'Ivoire	Indonesia	Mauritius	Qatar	Timor-Leste
Bahamas		Croatia	Iran	Mexico	Romania	Togo
Bahrain		Djibouti	Iraq	Micronesia	Russian Federation	Tokelau
Bangladesh		Dominican Republic	Japan	Moldova-Rep. Mongolia	Rwanda	Tonga
Belarus		Ecuador	Kazakhstan	Montenegro	St. Vincent & The	Tunisia
Belize		Egypt	Kenya	Morocco	Mozambique	Turkey
Benin		El Salvador	Equatorial	Kiribati	Myanmar	Sao Tome & Principe
Bhutan	Bolivia	Guinea	Korea-DPR	Namibia	Saudi Arabia	Turkmenistan
Bosnia & Herzegovina		Eritrea	Korea-Republic	Nauru	Senegal	Tuvalu
Botswana		Estonia	Kuwait	Nepal	Seychelles	Uganda
Brazil		Ethiopia	Kyrgyzstan	New Caledonia	Nicaragua	Ukraine
Brunei Darussalam		Fiji	Lao PDR	Niger	Singapore	Uruguay
Bulgaria		French Polynesia	Latvia	Nigeria	Solomon Islands	Uzbekistan
Burkina Faso	Burundi	Gabon	Lesotho	Niue	Somalia	Vanuatu
Cambodia		Gambia	Liberia	N. Mariana Islands	South Africa	Venezuela
Cameroon		Georgia	Lithuania	Macedonia-	Pakistan	Viet Nam
Cape Verde		Ghana	TFYR	Palau	Spain	Wallis & Futuna Islands
Central African Republic		Guam	Madagascar	Panama	Sri Lanka	W. Bank & Gaza Strip
Chad		Guatemala	Malawi	Papua New Guinea	Sudan	Yemen
China		Guinea	Malaysia	Paraguay	Suriname	Zambia
Colombia		Guinea-Bissau	Guyana	Maldives	Peru	Syrian Arab Republic
						Zimbabwe
						Swaziland

If you answered **YES** to any of the Tuberculosis Screening & Symptom Assessment questions above you are considered **HIGH RISK** for Tuberculosis. You are **REQUIRED** to have a Mantoux test (PPD skin test) or IGRA (Interferon Gamma Release Assay) blood test. Anyone with a history of a positive Mantoux test should submit a radiologist report of a chest x-ray along with a physician report of TB treatment. Please call the Student Health Center at 856-256-4333 (selection option 1) with any questions.

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 and Severity

Viral meningitis is more common than bacterial meningitis, and usually occurs 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 US 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 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 or 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.

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 meningitis immunization on Immunization Records)

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

Date

Rowan ID #