

NJCU HEALTH AND WELLNESS CENTER

2039 Kennedy Blvd., Jersey City, NJ 07305-1597 Vodra Hall, Suite 107 (201) 200-3456 or 3457 Fax: (201) 200-2011

Email: HWC@NJCU.EDU

ENTRANCE HEALTH RECORD

DIRECTIONS: The Entrance Health Record is to be **completed by the student** and returned to the Health and Wellness Center at the above address. **DO NOT send the form to the Admissions Office**. All medical / immunization information is confidential and will not be released without the student's written permission with the exception of vital information in case of a medical emergency.

Parent or quardian's signature is required if the student is under the age of 18. **INCOMPLETE FORMS ARE NOT ACCEPTED**Students who fail to comply will be blocked from second semester registration and excluded from University housing

Undergraduate Graduate Re-Admit Certification Other ____ PLEASE CHECK: Transfer Summer YEAR: _____ Do you plan to live on campus? Yes Starting Semester: Fall Spring No PLEASE PRINT ALL INFORMATION, EXCEPT WHERE A SIGNATURE IS REQUIRED - PLEASE USE INK First: NJCU Student ID # (if known) or Maiden/Former Name: _____ Last **4** digits of SSN # _____ Date of Birth ___/__ / __ Gender __ Address City or Town State Street (Permanent Home) Zip Address _ (Local, if different from above) Street City or Town State Zip Phone (Cell) ______ Home _____ Work __ _____ Work Phone # _____ Cell Phone # _____ company name and policy number of the insurance: ______ MOST RECENT HEALTHCARE PROVIDER: (Name) Address: ______Phone # _____ **MEDICAL CONSENT AND RELEASE:** Permission is hereby given to perform routine health examination, provide preventative measures, medical treatment and first aid at the Health and Wellness Center of New Jersey City University and to make necessary referrals. I also consent to the release of my University medical records to appropriate health care providers in the event of an emergency.

(If student is under 18 years of age, parent or legal guardian must sign here)

PERSONAL HISTORY

NEW JERSEY

This section must be completed and signed/stamped by a physician or health care provider OR a copy of your immunization records must be attached

IMMUNIZATION EXEMPTIONS

(If you are applying for EXEMPTION, please beeck belowandyou MUST provide the information required for the exemption)

<u>Immune Status Exemption</u> – ANTIBODY TITERS (BIOOD TEST) <u>Copy of laboratory report showing that you are immune is required.</u> Only positive or immune titers will be accepted. <u>Equivocal results are NOT acceptable</u>.

<u>Age Exemption</u> - Born prior to January 1, 1957 (valid for MMR immunization exemption only) – There is NO AGE exemption for the Hepatitis B immunization or the Meningitis campus housing