

# GRADUATE/LAW HEALTH FORM



Dear Student,

The State of New Jersey requires all college students to provide basic health information to their institutions prior to matriculation. The information on this health form is considered confidential and will not be shared with anyone outside University Health and Counseling Services without your explicit permission. To provide optimum patient care, consultations between professionals within our department (Health and Counseling) may occur.

**Forms with incomplete or unanswered questions will not be accepted.  
STUDENTS WHO DO NOT SUBMIT A COMPLETED FORM WILL NOT BE ABLE TO REGISTER.**

**Completed forms must be submitted by August 1 (Fall Semester) & December 15 (Spring Semester) to:**  
Immunization Coordinator, University Health Services, Department of Health and Counseling Services  
Seton Hall University, 400 South Orange Avenue, South Orange, New Jersey 07079

*Should you have any questions, please contact Health and Counseling Services between the hours of 9 a.m. and 4:45 p.m. (Monday – Friday)*

**Health Services:** Phone (973) 761-9175 • Fax (973) 761-9193

Health Services Location: 303 Centre Street

**Counseling Services:** Phone (973) 761-9500 • Fax (973) 275-2415

### PERSONAL INFORMATION - Please print or type.

Name \_\_\_\_\_ SHU ID \_\_\_\_\_  
last first middle

Home Address \_\_\_\_\_  
number and street city county state zip

Telephone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ U.S. Citizen  Yes  No

Name, Address and Phone Number of Nearest Kin (such as parent or guardian) \_\_\_\_\_

Insurance Carrier and Policy Number \_\_\_\_\_

Month and Year of Entry into Law/Graduate School \_\_\_\_\_

### FAMILY HISTORY

Age and health, if living, or cause of death:

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

### PERSONAL HISTORY

All medical information is strictly confidential. **(Please provide details of all positive answers under remarks.)**

	YES	NO		YES	NO
Any history of reaction to medication, latex, food and/or serum? <i>(Specify reaction under remarks.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Serious reaction to insect bites or food	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cycle disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever, hives, seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	Disabling loss of vision, hearing	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<i>(Please note quantity under remarks.)</i>		
Heart murmur or any disorder of the heart	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced a problem with drug or alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced a severe dietary problem (anorexia, bulimia, obesity)?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid or endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious head injury, illness, hospitalization or operation?	<input type="checkbox"/>	<input type="checkbox"/>
Colitis, irritable bowel or Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a need for personal counseling?	<input type="checkbox"/>	<input type="checkbox"/>
Shingles (Herpes Zoster)	<input type="checkbox"/>	<input type="checkbox"/>	Would you like information about counseling services?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones or history of kidney disease	<input type="checkbox"/>	<input type="checkbox"/>			
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			

Remarks: \_\_\_\_\_

Please list any medications you use on a regular basis. *(Include amount and usage per day.)* \_\_\_\_\_

IMMUNIZATION HISTORY

PLEASE NOTE THAT A COMPLETE UPDATED IMMUNIZATION SCHEDULE IS REQUIRED FOR REGISTRATION.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

A.  TETANUS DIPHTHERIA (Td) \_\_\_\_\_ month/day/year

TETANUS DIPHTHERIA ACELLULAR PERTUSSIS (Tdap)

1. Received most recent booster WITHIN THE LAST 10 YEARS ..... \_\_\_ / \_\_\_ / \_\_\_

\*B. M.M.R. (Measles, Mumps, Rubella combined)

1. Born before 1957 and therefore considered immune.

2. Dose 1 - Immunized ON OR AFTER THE FIRST BIRTHDAY ..... \_\_\_ / \_\_\_ / \_\_\_

3. Dose 2 - Immunized at least one month after Dose 1 ..... \_\_\_ / \_\_\_ / \_\_\_

\*C. MEASLES

1. Dose 1 - Immunized ON OR AFTER THE FIRST BIRTHDAY ..... \_\_\_ / \_\_\_ / \_\_\_

2. Dose 2 - Immunized at least one month after Dose 1 ..... \_\_\_ / \_\_\_ / \_\_\_

\*D. RUBELLA

1. Immunized ON OR AFTER THE FIRST BIRTHDAY ..... \_\_\_ / \_\_\_ / \_\_\_

\*E. MUMPS

1. Dose 1 - Immunized ON OR AFTER THE FIRST BIRTHDAY ..... \_\_\_ / \_\_\_ / \_\_\_

2. Dose 2 - Immunized at least one month after Dose 1 ..... \_\_\_ / \_\_\_ / \_\_\_

\* B. through E.: If documentation of vaccine is unavailable, an immune titre blood test is required (please include copy of results). If the titre does not indicate immunity, a vaccine is required.

F. MENINGITIS - (REQUIRED FOR ALL INCOMING RESIDENTIAL STUDENTS.) ANY STUDENT WHO WISHES TO REDUCE HIS OR HER RISK OF DISEASE CAN CONSIDER THE VACCINE.

1. Check one:  Menactra  Menomune ..... \_\_\_ / \_\_\_ / \_\_\_

G. TUBERCULOSIS

(PPD still required unless patient provides documentation of previous positive PPD.)

1. Mantoux test required within past year; tine or monovac not accepted. (PPD MUST be read within 48 to 72 hours by R.N., N.P. or M.D.)

Give date and test results:

Results: Size of induration \_\_\_\_\_ mm Applied \_\_\_ / \_\_\_ / \_\_\_ Read \_\_\_ / \_\_\_ / \_\_\_

2. Positive PPD: Size of induration \_\_\_\_\_ mm

Anyone with a history of a positive PPD must enclose copies of pertinent medical records.

Chest x-ray required within one year of entry with positive or history of positive PPD.

Give date and result of chest x-ray ..... \_\_\_ / \_\_\_ / \_\_\_

Result:  Positive  Negative

3. Date of completion of six months to one year of Isoniazid therapy (INH)..... \_\_\_ / \_\_\_ / \_\_\_

4. Had BCG vaccine administered ..... \_\_\_ / \_\_\_ / \_\_\_

(PPD still required unless patient has documentation of previous positive PPD)

H. COMMENTS: \_\_\_\_\_

I acknowledge that all information provided is accurate.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_