
STUDENT HEALTH FORMS CHECK LIST

- Read page titled, “**IMPORTANT INFORMATION**”
- Placed **Banner Student ID number and your name** on each page.
- Completed **HEALTH HISTORY FORM**
- IMMUNIZATION FORM (completed)** with health care provider signature. This may be signed by any person authorized by law to administer an immunization. We will accept a copy of a immunization record from a physician’s office.

*If you plan to submit proof of immunity by using measles, mumps or rubella titers rather than using vaccination records, you **MUST** submit actual laboratory results including reference range and the results **MUST** verify immunity.*

For information on meningococcal vaccines, visit:

<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf>

- INTERNATIONAL STUDENTS** must comply with Immunization requirements set forth by New York State law before arrival to Alfred University. Failure to do so may result in the inability to register for classes or create additional costs to you as a student.
- TUBERCULOSIS SCREENING** form completed and signed by health care provider.
- PHYSICAL FORM** completed and signed by health care provider.
- MENINGITIS RESPONSE** form completed and signed by student (parent, if under 18).
- HEALTH INSURANCE INFORMATION FORM**

It is the expectation of Alfred University for all students to have their own health insurance. All student athletes, however, are mandated to have health insurance. In order to update our systems as well as to best serve our students, please fill out the following Health Insurance Form.

NOTE: To assure your forms are received by the Health Services Office please mail to this address before July 20, 2016:

**Alfred University
Health Services
Attention: Health Forms
1 Saxon Drive
Alfred, NY 14802**

IMPORTANT INFORMATION

Dear Student:

Welcome to Alfred University!

Enclosed you will find the required immunization form, health history form, physical examination form, tuberculosis screening form and Meningococcal Meningitis vaccination response form, to be completed by you and/or your health care provider. Please look these forms over carefully before your visit with your health care provider to help assure proper completion of the forms. A checklist is enclosed to help you be sure you have read and completed all pertinent information. If you are under the age of 18, a parent or guardian will need to provide consent for treatment with each visit to health services. Also be aware that treatments provided by health services are confidential for all students aged 18 and over; health services cannot share any information with anyone, including parents, without your informed, written consent.

If you were born after January 01, 1957, NYS Public Health Law #2165 requires that we have written documentation of two measles, one mumps and one rubella (MMR) immunization. The documentation must be legible and written/translated in English. Students who do not comply will not be able to register for classes, and will be withdrawn from college and denied attendance to classes. Please keep a copy of your immunization record for your own future needs. It is recommended that all college students *consider* receiving the Meningitis vaccine prior to entering school. You *must* complete the enclosed acknowledgement section on the Health History form even if you decide not to receive the meningitis vaccine.

New York State Department of Health and AU Health Services has very specific requirements as to what constitutes an acceptable record of immunization. If you have any questions or concerns as to whether the immunization record you are submitting will comply, please call AU Health Services at 607-871-2400.

There are options regarding payments for services provided at AU Health Services. Please note that billing for private insurances is the sole responsibility of the student or his/her family. Itemized statements for private insurance billing are available to students upon request.

The AU Health Services Team looks forward to the opportunity to help you with your health and wellness needs during the academic year. Students are encouraged to maintain a relationship with a primary healthcare provider who can provide and coordinate health care year round. To run Health Services more efficiently, we find that working on an appointment basis is beneficial to both students and health services operations. **Except in the event of an emergency, please call in advance to schedule an appointment.**

In closing, we hope your experience at Alfred University is a fulfilling and healthy one. We welcome any questions you or a parent may have. Feel free to contact us at any time.

Return Completed Form To:

Alfred University
Health Services
Attention: Health Forms
1 Saxon Drive
Alfred, NY 14802
Phone: (607) 871•2400
Fax: (607) 871•2631

All Health Forms must be received before July 20, 2016 and on file before a student can register for classes.

HEALTH HISTORY FORM

Banner ID # A00 _____

FOR THE STUDENT - You will not be permitted to register until this completed form is received by the Wellness Center. You and/or your parents must complete this form before seeing your healthcare provider, who completes the PHYSICAL FORM.

_____/_____/_____
 Last Name First Name Middle Name Birthdate

 Home Address (Street & No.) City/Town State Zip Age M F Other
 Sex

Student's Cell Phone #: _____ Home Phone #: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Cell Phone #: _____

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Please read the enclosed information regarding Meningococcal Disease and the availability of a vaccination against this disease. This vaccination can be obtained through special order for administration at Health Services (please call for an appointment). Please note that NYS Public Health Law requires you to complete the following section on meningococcal meningitis vaccine. You must comply with this law before you can register for classes.

If you have chosen to decline the Meningitis vaccine, please check the box below and sign on the line indicated.

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease. I understand that although I have declined the vaccine at this time, I have the right to request the vaccine at any time in the future.

(Note: If you received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine's protection lasts for approximately 3-5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.)

Student Signature (Parent, if under 18) _____ **Date:** _____

If you have received the Meningitis vaccine, this MUST be recorded by your health care provider on the immunization form.

Have you ever had: Yes or No

Allergy to any medications _____	Heart Murmur _____	Hospitalization _____
Chicken Pox (Date) _____	Eating disorder _____	Surgery(s) _____
Diabetes _____	Mental Illness _____	Alcohol/Drug Abuse _____
Mononucleosis (Mono) _____		

CHECK THE FOLLOWING BOXES ONLY IF THEY PERTAIN TO YOU AS A STUDENT.....

AU Health Services is able to provide continuation of some **allergy injection programs** provided the student is on maintenance doses, only. If you wish to continue an allergy regimen at **AU Health Services**, please check this box. We will send you additional information regarding our policy and procedure. Provisions must be made with us **BEFORE** receiving allergy shots at AU Health Services. **Students/parents should contact AU Health Services at least two months prior to the beginning of the semester.**

Student Signature: _____ **Date:** _____

By marking this box, I authorize AU Health Services staff to provide to the Alfred University Counseling Services, information about me for the purpose of evaluating needs and providing services. I understand that I may be contacted by the Counseling and Wellness Center to further assist me or provide services to me which may be needed for my care. This authorization may include disclosure of information related to alcohol and drug abuse or mental health treatment. I understand this authorization is voluntary and I may revoke this authorization at any time in writing except to the extent that action has already taken place. This authorization does not authorize Alfred University Health Services to discuss my health information or medical care with anyone other than the Alfred University Counseling Services.

Student Signature: _____ **Date:** _____

IMMUNIZATION FORM: MUST BE RECEIVED BEFORE July 20, 2016

Banner ID # A00 _____

Name: _____ Date of Birth: _____
 Student's Cell # or phone # where student can be reached _____
 Student's email address: _____

Students born on or after January 1, 1957 must comply with New York State Public Health Law 2165 requiring immunization dates for measles, mumps, and rubella. All dates should include month, day and year. Forms must be complete, and be typed or printed in the English language.

Measles (Rubeola): Two live doses of measles are required. First dose must be given after the first birthday and the second dose must be given after fifteen months of age and at least thirty (30) days after the first dose.

MMR: (Combined measles, mumps, rubella) #1 _____ #2 _____
 (M / D / Y) (M / D / Y)

Or Date of first live dose of measles given: _____
 (M / D / Y)

Date of second live dose of measles given: _____
 (M / D / Y)

Or **Positive** measles titer (Copy of result with laboratory reference range must be attached)

Mumps: (One mumps dose is required and must be given after the first birthday) Date of live mumps vaccination given: _____
 (M / D / Y)

Or **Positive** mumps titer (Copy of result with laboratory reference range must be attached)

Rubella (German Measles): (One dose is required & must be given after the 1st birthday) Date of live rubella vaccination given: _____
 (M / D / Y)

Or **Positive** rubella titer (Copy of result with laboratory reference range must be attached)

Hepatitis B: (Recommended, not required) #1 Date _____ #2 Date _____ #3 Date _____
 (M / D / Y) (M / D / Y) (M / D / Y)

Hepatitis A: (Recommended, not required) #1 Date _____ #2 Date _____
 (M / D / Y) (M / D / Y)

Varicella: #1 Date _____ #2 Date _____ or Date of Disease: _____
 (M / D / Y) (M / D / Y) (M / D / Y)

(Recommended without other evidence of immunity)

Meningitis Vaccination: (Recommended not required) Date: _____ Check One: Menactra™ Menomune™ Menveo™
 (M / D / Y)

IMPORTANT: Students who have chosen NOT to receive the Meningitis vaccination MUST complete the statement on the Health History Form indicating the vaccine has been declined.

Tdap: (Within last 10 years) _____ or **Td** _____
 (M / D / Y) (M / D / Y)

HPV Vaccine: _____
 (M / D / Y) (M / D / Y) (M / D / Y)

Polio: (Date series was completed) _____
 (M / D / Y)

Healthcare Provider Signature: _____ **(Required)** **Date:** _____
 (Any person authorized by law to administer immunizations)

Healthcare Provider, Printed Name and Phone #	For AU Office Use Only: Immunizations given at AU Health Services	
	Immunization	Date

PHYSICAL FORM

Banner ID # A00_____

For the **HEALTHCARE PROVIDER:**

Date: _____ Name: _____ Race (optional): _____

HGT: _____ WGT: _____ Build: Slender Medium Heavy Obese

Temperature: _____ B/P: _____ / _____ Pulse _____

Allergies: _____ Current Medications: _____

Vision: No Lenses Lenses R: 20/_____ L: 20/_____

If there is a significant health issue that is important for us to be aware of, please describe on a separate sheet and attach.

Check Each Item in Proper Column: (Enter NE if not evaluated)

	Normal	Abnormal	Comments
1. Head, Neck, Face Nose and Sinuses			
2. Mouth and Throat			
3. Teeth and Gingiva			
4. Ears			
5. Eyes			
6. Pupils and Ocular Motion			
7. Lungs, Chest, Breasts			
8. Heart			
9. Vascular System (Varicosities, etc.)			
10. Abdomen and Viscera (include hernia)			
11. Genital (if appropriate)			
12. Ano-rectal (pilonidal)			
13. Endocrine System			
14. G-U System			
15. Upper Extremities (strength, ROM)			
16. Feet			
17. Lower Extremities			
18. Spine, other musculo-skeletal			
19. Skin & Lymphatics			
20. Neurologic			
21. Psychiatric (specify)			

Is there loss or seriously impaired function of any organ? Yes No If Yes, Please Explain: _____

Are there any restrictions of physical activity indicated by your exam? Yes No If Yes, Please Explain: _____

Is the student now under treatment for any medical or emotional problem? Yes No If Yes, Please Explain: _____

I have examined the above named student and it is my professional opinion that the student is physically and psychologically able, except as noted above, to undertake college studies.

Examining Healthcare Provider Signature: _____ **Print Name:** _____

Address/City/State/Zip: _____ **Phone:** _____ **Fax:** _____

MANDATORY TUBERCULOSIS SCREENING FORM

Banner ID # A00 _____

Name: _____

Date of Screening _____

1. Has the student ever had a positive PPD test? YES NO

If NO, proceed to question 2.

If YES, do not repeat PPD test. Proceed to questions 4-6 and supply information.

2. Does the student have signs or symptoms of active TB disease such as night sweats, weight loss, persistent cough or bloody sputum? YES NO

If NO, proceed to question 3.

If YES, proceed with additional evaluation to rule out active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated, questions 3-6.

3. Is the student a member of a high-risk group** or is the student entering the health professions? (See below) YES NO

If NO, STOP! No further evaluation or skin test is needed at this time. Healthcare Provider, please sign below.

If YES, place tuberculin skin test. (Mantoux only: Inject 0.1ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermal into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

4. Tuberculin Skin Test:

Date given: ____/____/____ Date read: ____/____/____

Record actual mm of induration, transverse diameter; if no induration, write "0"

Result: _____ mm Interpretation: Positive Negative (based on mm of induration as well as risk factors)

5. Chest X-ray (required if tuberculin skin test is positive): Date of chest x-ray ____/____/____
Result: Normal Abnormal

6. History of any previous treatment: (Please list medications used and dates of treatment duration)

Healthcare Provider Signature: _____

*Based on recommendations by the American College Health Association (ACHA), Centers for Disease Control and the American Thoracic Society.

**Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from another country with the EXCEPTION of Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have 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; those who have had contact with a known case of TB; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥ 15 mg/d for ≥ 1 month) or other immunosuppressive disorders.

HEALTH INSURANCE FORM

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Student Information

First Name _____
Last Name _____
School Email _____
Banner ID # _____
Date of Birth _____

Primary Health Insurance Information (Policy Holder)

First Name (Policy Holder) _____
Last Name (Policy Holder) _____
Address (Policy Holder) _____

Name of Insurance Company

Member ID _____

Members Services Phone Number (on Card)

Phone Number (Policy Holder) _____

Policy Holder Date Of Birth _____

***** Please Include Copy of Insurance Card (Front & Back) *******

Send to: Alfred University
Health Services
1 Saxon Drive
Alfred, NY 14802