Alfred University Wellness Center
Health Services
Phone: 607-871-2400 / Fax: 607-871-2631

1 Saxon Drive
Alfred, NY 14802
https://healthdocs.alfred.edu

STUDENT HEALTH FORMS: IMPORTANT INFORMATION!

PLEASE READ THE FOLLOWING HEALTH FORM REQUIREMENTS. NON-COMPLIANCE WILL RESULT IN A HOLD ON YOUR ACCOUNT, PREVENTING YOU FROM REGISTERING FOR CLASSES AND RECEIVING ANY ACADEMIC CREDIT.

Measles, Mumps, Rubella: *(NOT required if you were born BEFORE January 1, 1957)*

- NYS Public Health Law #2165 requires that we receive written documentation of measles, mumps, and rubella vaccination or immunity. This can be achieved by the following:
  - Documentation of vaccination for measles (2 doses), mumps (1 dose), and rubella (1 dose). Vaccinations may be given individually or collectively as the MMR. OR,
  - Documentation of titers that demonstrate immunity. This is a blood test that measures antibodies you have for measles, mumps, and rubella. If immunity is NOT demonstrated with titers, you must be vaccinated as is outlined above.
- Documentation for measles, mumps, and rubella vaccinations MUST be signed by your primary care provider. A copy of your vaccination record with your name on it will be accepted. If titers are submitted, a copy of the actual documentation from the performing laboratory is required. Alternatively, if you have attended another secondary institution and have records indicating compliance with this requirement, we will accept a copy of this as proof.

Meningitis:

- Alfred University requires one of the following:
  - Proof of a meningitis vaccination within the last five years. OR,
  - Signed form (see enclosed) indicating that you are making an informed decision to decline receiving a meningitis vaccine at this time.

Tuberculosis Screening: *(NOT REQUIRED FOR STUDENTS IN THE CITE PROGRAM)*

- Alfred University requires tuberculosis (TB) screening using the following directions (see enclosed form for more detailed information):
  - A brief questionnaire. If all question responses are "NO," compliance is met. If not, then please submit:
  - The results of a tuberculin skin test. Must be completed within one year and be signed by a primary care physician. If results are negative, compliance is met. If positive, please submit:
  - The results of a chest x-ray. Must be completed within one year and be signed by a physician. In the absence of any signs of active TB, compliance is met.
- If you have been treated for TB, please list medications used, dates of treatment, and disease duration.

ONCE COMPLIANCE IS MET WITH THE ABOVE THREE REQUIREMENTS, YOUR HEALTH SERVICES HOLD WILL BE REMOVED. THERE ARE NO EXCEPTIONS, AS WE ARE STRICTLY FOLLOWING NYS LAWS AND ALFRED UNIVERSITY POLICIES. PLEASE ALLOW YOURSELF ADEQUATE TIME TO COMPLETE THESE REQUIREMENTS SO YOU CAN REGISTER FOR CLASSES.

Other requirements:

In addition to the above, please submit the following:

- Complete immunization record
- Physical form completed and signed by your primary care physician
- Health history form (also contains the meningitis response) ▪ Copy of health insurance card (front and back)
  ** If policy holder is NOT the student, please include policy holder's full name, DOB, and contact information*
- If student plans to receive allergy shots while at school, please contact us ASAP for an information packet

PLEASE SUBMIT ALL DOCUMENTATION VIA MAIL, WEBSITE (https://healthdocs.alfred.edu) OR FAX (INFORMATION IN LETTERHEAD ABOVE) BY JULY 1. Email is not a confidential means of communication.

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IMMUNIZATION FORM: Please complete the following form and have it signed by your primary care provider; OR submit a complete immunization record.

Name_____ **Date of Birth** _____ **Banner ID** _____

Measles, Mumps, Rubella: Must document either dates of vaccinations or proof of immunity (titers).

- Measles (Rubeola): Two live doses of measles are required. The 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.
- Mumps: One mumps dose is required and must be given after the first birthday.
- Rubella (German Measles): One rubella dose is required and must be given after the first birthday.

Please document date received (M/D/Y):

MMR: (Combined measles, mumps, rubella) 1:_____ 2:_____

OR Measles vaccine: 1:_____ 2:_____

Mumps vaccine: _____ Rubella vaccine: _____

OR **Positive** titers for measles, mumps, and rubella: ***(Copy of result from performing laboratory with reference range for each antibody must be attached)***

Meningitis Vaccination: (Recommended, not required, please sign acknowledgement if declined)
Please document date received (M/D/Y): (second line included for booster if first dose prior to age 16 years

1: _____ Circle one: Menactra™ Menomune™ Menveo™ Booster: _____

COVID – 19:
Manufacturer: _____ Date of 1st Dose: _____ Date of 2nd Dose: _____
Date of 3rd Dose (Booster): _____

Hepatitis B: (Recommended, not required) *Please document date received (M/D/Y):*

1:_____ 2: _____ 3: _____

Hepatitis A: (Recommended, not required) *Please document date received (M/D/Y):*

1:_____ 2: _____

Tdap/Td: (Within 10 yrs) _____ **HPV Vaccines:** 1: _____,2: _____, 3:_____

Healthcare Provider Signature: (Required)_____ **Date:**_____
(Please provide stamp/contact information)

Alfred University Wellness Center Health Services

Dear Student/Parent

As the Health Services director at Alfred University, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. New York State Public Health Law (NYS PHL) §2167 requires institutions, including colleges and universities, to distribute information about meningococcal disease and the available vaccine to all students meeting the enrollment criteria, whether they live on or off campus.

Alfred University is required to maintain a record of the following for each student:

- A record of meningococcal immunization within the past 5 years; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal immunization signed by the student or student's parent or guardian (if < 18 yrs. of age).

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illnesses such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacterium that causes meningococcal disease even before they know they are sick. There have been several outbreaks of meningococcal disease at college campuses across the United States.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause about two-thirds of meningococcal disease in the United States. The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series. They should discuss the MenB vaccine with a healthcare provider.

All private insurance plans not grandfathered under the Affordable Care Act are required to cover the cost of MenACWY and MenB vaccines. Contact your health insurance plan to determine whether it covers MenACWY and MenB vaccines. The federal Vaccines for Children (VFC) and NYS Vaccines for Adults (VFA) programs will cover both MenACWY and MenB vaccines for children and adults who have no health insurance or whose health insurance does not cover these vaccines, as well as for children less than 19 years of age who are American Indian or Alaska Native or eligible for Medicaid or Child Health Plus.

While Alfred University Health Services does not offer meningococcal vaccines, we can assist in a referral to the Allegany County Health Department Immunization Clinic who does offer them or consult your primary care physician.

On the Health History Form, complete the meningococcal vaccination response form only if you decide not to receive the vaccine prior to arrival on campus.

To learn more about meningococcal disease and the vaccine, please feel free to contact our health service and/or consult your physician. You can also find information about the disease on the Centers for Disease Control and Prevention website at www.cdc.gov/meningococcal/.

Sincerely,

Susan Hendee, NP
Assistant Director of Wellness Center

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HEALTH HISTORY/MENINGITIS RESPONSE FORM:

For the student: Please complete the following form. It does not need to be signed by your primary care physician.

_____ _____ _____ _____

Last Name First Name Middle Name Birthdate

_____ _____

Home Address (Street & No.) City/Town State Zip Gender

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

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

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)	_____				

If "Yes" to any of the above, please specify: _____

Do you have any special dietary needs or restrictions? Please spedify: _____
If so, do we have your permission to share these needs/restrictions with dining services to ensure that options are available to fit your needs?

☐ Yes ☐ No ☐ Not Applicable

MENINGITIS VACCINATION RESPONSE FORM

Please read the enclosed information regarding meningitis and the availability of a preventative vaccine.
Note that NYS Public Health Law 2167 requires you to complete the following section in the absence of vaccination.

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 (my child) will **not** obtain immunizations 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.

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

Student Name (print)_____**Date of Birth**_____**Banner ID**_____

If you have received the Meningitis vaccine, this MUST have been within the last five years and documentation must be provided, using the guidelines outlined above for proof of vaccination.

By signing here, I authorize AU Health Services staff to provide AU Counseling Services information about me for the purpose of evaluating needs and providing services. I understand that I may be contacted by the Counseling Services 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 AU Health Services to discuss my health information or medical care with anyone other than the AU Counseling Services.

Student Signature: _____ **Date:** _____

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MANDATORY TUBERCULOSIS SCREENING FORM

Banner ID # A00_____

Name: _____ Date of Screening: _____

		Yes	No
1.	Has the student ever had a positive PPD test?	☐	☐
2.	Does the student have signs or symptoms of active TB disease such as night sweats, weight loss, persistent cough, or bloody sputum OR Is the student in a high-risk category? *	☐	☐
3.	To the best of your knowledge has the student ever had close contact with anyone who was sick with tuberculosis (TB)?	☐	☐
4.	Was the student born in one the countries listed below?	☐	☐
5.	Has the student traveled or lived *for more than one month* in one or more of the countries listed below?	☐	☐

* High-risk individuals include those who: have an HIV infection; inject drugs; work closely with AIDS patients at residential settings; receive prolonged corticosteroid therapy; or have an immunosuppressive disorder

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)

World Health Organization Global Health Observatory, Tuberculosis Incidence 2015

Afghanistan	Colombia	Indonesia	Myanmar	Solomon Islands
Algeria	Comoros	Iraq	Namibia	Somalia
Angola	Congo	Kazakhstan	Nauru	South Africa
Anguilla	Côte d'Ivoire	Kenya	Nepal	South Sudan
Argentina	Democratic People's Republic of Korea	Kiribati	New Caledonia	Sri Lanka
Armenia	Democratic Republic of the Congo	Kuwait	Nicaragua	Sudan
Azerbaijan	Djibouti	Kyrgyzstan	Niger	Suriname
Bangladesh	Dominican Republic	Lao People's Democratic Republic	Nigeria	Swaziland
Belarus	Ecuador	Latvia	Northern Mariana Islands	Syrian Arab Republic
Belize	El Salvador	Lesotho	Pakistan	Tajikistan
Benin	Equatorial Guinea	Liberia	Palau	Tanzania (United Republic of)
Bhutan	Eritrea	Libya	Panama	Thailand
Bolivia (Plurinational State of)	Ethiopia	Lithuania	Papua New Guinea	Timor-Leste
Bosnia/Herzegovina	Fiji	Madagascar	Paraguay	Togo
Botswana	Gabon	Malawi	Peru	Tunisia
Brazil	Gambia	Malaysia	Philippines	Turkmenistan
Brunei Darussalam	Georgia	Maldives	Portugal	Tuvalu
Bulgaria	Ghana	Mali	Qatar	Uganda
Burkina Faso	Greenland	Marshall Islands	Republic of Korea	Ukraine
Burundi	Guam	Mauritania	Republic of Moldova	Uruguay
Cabo Verde	Guatemala	Mauritius	Romania	Uzbekistan
Cambodia	Guinea	Mexico	Russian Federation	Vanuatu
Cameroon	Guinea-Bissau	Micronesia (Federated States of)	Rwanda	Venezuela (Bolivarian Republic of)
Central African Republic	Guyana	Mongolia	Sao Tome and Principe	Viet Nam
Chad	Haiti	Montenegro	Senegal	Yemen
China, Hong Kong SAR	Honduras	Morocco	Serbia	Zambia
China, Macao SAR	India	Mozambique	Sierra Leone	Zimbabwe
			Singapore	

- If you answered **YES** to <u>any</u> of the above questions, you are considered "high-risk" and are required to submit documentation of recent PPD testing. PPD testing should be within the last 12 months, or after extended travel to a high incidence country. If done, please enter results below (must be signed by healthcare provider).

PPD skin test results: Date given: _____ Date read: _____ Interpretation: □Positive (≥10mm) □Negative
Record actual mm of induration, transverse diameter (if no induration, write "0"): Result: _____mm

- If you answered **NO** to all of the above questions, then you are considered "low-risk" and a PPD test is not required.

<u>If the PPD test is positive, you must submit a copy of a chest x-ray report (in English) dated within the last 6 months.</u>

Healthcare Provider Signature: _____

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PHYSICAL FORM: To be completed by the **Healthcare Provider**: **Banner ID # A00_ _ _ _ _ _**

Date of Exam: _____ Name of Student: _____

HGT: _____ WGT: _____ Temperature:_____ B/P: _____/_____ Pulse_____
Allergies (include medication 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. 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 limb or 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:** _____

Alfred University Wellness Center

Authorization Form for Medical Treatment and/or Counseling

Please complete this form if your child will be under the age of 18 years while on campus:

Student Name:_____ Student DOB:_____ Banner ID#:_____

Person to notify in the event of an emergency: _____

As the parent/guardian of _____(print student's name), I hereby authorize the medical and counseling staff of Alfred University Wellness Center, to evaluate, advise, perform any diagnostic procedure (on-site or via referral), and/or provide treatment/counseling as deemed advisable and is under the supervision of a licensed medical provider/licensed mental health counselor. I understand that until the student is 18 years of age, I have a right to be informed of this care, except under certain circumstances as prescribed by the Medical Practice Act. At the time the student turns 18 years old, he/she will be able to consent to his/her own care and this authorization will no longer apply.

Parent/Guardian Name:

(print) _____ (signature) _____

Date:_____

Telephone Number (s):_____

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HEALTH INSURANCE FORM

All registered undergraduate students and graduate students (matriculating and non-matriculating) attending Alfred University are expected to carry health insurance. Students are strongly encouraged to provide proof of insurance coverage prior to their arrival on campus by completing this form and returning it to the Health Service. If you do not have insurance, we have a list of plans available at the Health Service website.

All (J-1) International students are required to enroll in the school sponsored plan unless they provide proof of adequate coverage prior to their arrival on campus.

Student Information

First Name _____

Last Name _____

School Email _____

Student 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 Service Phone Number (on Card)

_____

Phone Number (Policy Holder) _____

Policy Holder Date Of Birth _____

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