WELCOME TO ST. BONAVENTURE !

The St. Bonaventure Center for Student Wellness joins the rest of the Bonaventure Family, welcoming you at the start of this **extraordinary journey** at **St. Bonaventure University**. We are part of the Student Life Division. Our goal is to promote the Bona student population to invest in their physical and emotional wellbeing. The Center for Student Wellness staff is currently in the planning phase, developing evening programs with topics that are relevant to our students. Examples of such groups are Social Anxiety, Test Anxiety, Autism Spectrum Disorder as well as Students with Chronic Health Issues, to name a few.

ST. BONAVENTURE UNIVERSITY
Founded 1858

St. Bonaventure University's Center for Student Wellness Counseling Services would like to invite students to contact our department to be paired with a counselor to assist with the adjustment to the university environment or any specific mental health needs. **All interactions are confidential** and the counselors are available and willing to provide short or long term relationships that best meet the needs of the student. Please call **716.375.2310** or drop by Doyle Hall Room127 to inquire about the services provided and/or to make an appointment.

St. Bonaventure Center for Student Wellness Health Services welcome students to contact our department for evaluation and/or treatment of acute/episodic illnesses (cough, colds, fever, minor injuries and management club sports related injuries etc.) by our medical provider Mondays, Wednesdays, and Fridays. On Tuesdays and Thursdays, students may obtain over the counter medicines such as Acetaminophen, Ibuprofen, cough/cold products, ice/heat packs, and assistance in obtaining further medical attention if required. Please call **716.375.2310** or drop by Doyle Hall Room 127 to inquire about the services provided and/or to make an appointment.

Before July 25th, 2016

All Fall of 2016 St. Bonaventure in-coming Freshman and Transfer Students are required to complete and submit the Mandatory Health Evaluation Forms and Immunization Records to The Center for Student Wellness Health Service Department.

The information provided with the completion of the MHEF's as well as Immunization Records enable SBU Health Service staff to provide optimal health care as well as to assure that all SBU students comply with New York State Public Health Laws 2165 and 2167 regarding required immunizations.

The Mandatory Health Evaluation Forms are available on the campus website in* the Student Life/Health Services *section.

Please return the completed Health Forms along with Records of requested Immunizations using the preferred methods listed below.
Methods are listed in preference with #1 being the top choice.

1.) Scan and Email to : CSWSBU@sbu.edu

2.) Fax : 716-375-7892

3.) Mail: St. Bonaventure University
The Center for Student Wellness
127 Doyle Hall, PO Box 2469
St. Bonaventure, New York 14778

°NCAA Student Athletes:
The Mandatory Student Health Evaluation Forms and Immunization Records must be completed and returned to The Center for Student Wellness BEFORE you arrive on campus to begin sports camps.

Veterans: We will temporarily accept a DD 214 for the immunization requirements if this has been issued within the past 10 years. Documentation of 2 MMR's and Meningitis (or Meningitis Response Form) pending actual receipt of immunization records from the armed services. If while awaiting the receipt of actual immunization records, a health risk shall arise at an institution, a student presenting a certificate under the terms of this subdivision shall be removed from the institution if proper immunization cannot be proved or otherwise rectified.

We greatly appreciate your assistances with completion of these forms in a timely manner.
The St. Bonaventure Center for Student Wellness Staff

Rev.mb5/20/16

Please check one:

___ **Fall Semester** **Year** _____

___ **Spring Semester** **Year** _____

___ **Summer Semester** **Year** _____

___ **Former SBU Student**
(last Semester attended) _____

St. Bonaventure University

Mandatory Health Evaluation Forms

for Undergraduate Students

(6 credit hours or more)

Forms due:

Fall Semester: July 25, 2016

Spring Semester: January 1, 2017

Please return completed forms to:

St. Bonaventure University
The Center for Student Wellness
127 Doyle Hall
PO Box 2469
St. Bonaventure, NY 14778
Phone 716-375-2310
Fax 716-375-7892
Email: CSWSBU@sbu.edu

ST. BONAVENTURE UNIVERSITY

Check All that Apply

___ **Freshmen**

___ **Transfer**

___ **Athlete**

___ **Sport**_____

___ **Residential Student**

___ **Commuter**

Date of Birth ____/____/____

Gender Identity (choose all that apply)

___ **Woman**

___ **Man**

___ **Trans or Transgender (please specify):**
_____

___ **Another Identity (please specify):**
_____

Please Print or Type

Name Last _____First _____ Preferred _____ Middle _____

Home Address Street _____ City _____

State _____ Zip _____ Country _____

Phone Home _____ Student's Cell _____

Person to be Notified In Emergency _____ **(**Relationship) _____

Phone Home _____Cell _____ Business _____

Health Care Provider; Doctor/NP/PA Name _____ Phone _____

Address Street _____ City _____ State _____ Zip _____

Insurance Information1.) Are you covered by health insurance? ( ) yes ( ) no

( ) Covered through parent or family policy ( ) Individual policy holder ( ) Purchased School Insurance

2. Please complete the information below **and** attach photocopy of insurance card (front and back)

NAME OF INSURANCE COMPANY _____

Address of Insurance Company _____

City _____ State _____ Zip _____ Phone _____

Policy Holders Name _____ Policy Holders Date of Birth____/____/_____ Relationship _____

Telephone _____ Place of Employment _____

POLICY INDENTIFICATION NUMBERS:

ID Number _____ Group Number _____

Please note: °Health Insurance is required for all Bonaventure students. If you presently are not covered by a Health Insurance Plan, information for obtaining insurance via St. Bonaventure will be available via my.sbu.edu through Haylor,Freyer & Coon, Inc. * If you presently have health insurance, **you will need to opt out of the Haylor, Freyer & Coon policy by signing the waiver at www.haylor-college.com. otherwise it will be billed to your SBU account.**

Summer waiver opens - 5/30/16 Closes- 6/30/16 Fall waiver opens 7/6/16 Closes 9/6/16 Spring waiver opens Mid December closes- 2/16/16

*Students Name _____

*Date of Birth _____/____/_____

Personal Health History

Have you had or do you have any of the following:

	NO	YES		NO	YES		NO	YES	
1.	( )	( )	Eye Disorders	20. ( )	( )	Blood Clotting Disorder	37. ( )	( )	MRSA
2.	( )	( )	Hearing difficulty	21. ( )	( )	Anemia	38. ( )	( )	Cancer
3.	( )	( )	Seasonal Allergies	22. ( )	( )	Diabetes	39. ( )	( )	Rheumatoid Arthritis
4.	( )	( )	Chronic Sinusitis	23. ( )	( )	Constipation	40. ( )	( )	Broken Bones
5.	( )	( )	Thyroid Disorders	24. ( )	( )	Stomach Ulcers	41. ( )	( )	Sprains /Dislocations
6.	( )	( )	Repeated Ear Infections	25. ( )	( )	Chronic Diarrhea	42. ( )	( )	Concussion
7.	( )	( )	Pneumonia	26. ( )	( )	Ulcerative Colitis/Crohn's	43. ( )	( )	Back problems
8.	( )	( )	Mono	27. ( )	( )	Liver Disease/Hepatitis	44. ( )	( )	Fainting episodes
9.	( )	( )	Asthma	28. ( )	( )	Kidney Disorders	45. ( )	( )	Seizure disorder
10.	( )	( )	Irregular Heart Beat	29. ( )	( )	Bladder Infections	46. ( )	( )	Migraine headaches
11.	( )	( )	Congenital Heart Defect	30. ( )	( )	Pelvic Infection/Pain	47. ( )	( )	Other physical disorders
12.	( )	( )	Heart Murmur	32. ( )	( )	Irregular Menstrual	48. ( )	( )	Alcoholism
13.	( )	( )	Rheumatic Heart Disease	33. ( )	( )	Hernia	49. ( )	( )	Drug dependency
14.	( )	( )	Heart Disease (under age 50)	34. ( )	( )	Pilonidal Sinus/Cyst	50. ( )	( )	Depression
15.	( )	( )	High Blood Pressure	35. ( )	( )	Skin Disorders: (Please Circle)	51. ( )	( )	Anxiety
16.	( )	( )	Repeated Strep Infections			Eczema/Psoriasis/ Severe Acne	52. ( )	( )	Eating Disorder
17.	( )	( )	Tooth /Gum Disease			Other _____	53. ( )	( )	Other Psychological
18.	( )	( )	Stroke	36. ( )	( )	Autism Spectrum Disorder			

NO YES

56. ( ) ( ) **Allergies to Medications**: Please list name of Medications and type of reaction:
_____
_____

57. ( ) ( ) Environmental allergies : Please list
_____
_____

58. ( ) ( ) Food allergies– Please list:
_____

59. ( ) ( ) Chemical or contact substances:
_____

60. ( ) ( ) Others– Please list:
_____

61. ( ) ( ) Are you currently taking any over the counter or prescribed medication on a regular or intermittent basis?
Name of medication and dosage:_____
Condition for which it is prescribed: _____
_____
_____

62. ( ) ( ) Have you ever been hospitalized for an illness or injury?
Date/Year ____/____/_____
Reason for hospitalization _____

63. ( ) ( ) *Do you have any chronic health problem which require regular treatment?

64. ( ) ( ) *Do you have a physical handicap or learning disability with which SBU may assist you?
If yes**, contact, ***The Teaching and Learning Center
Doyle Hall, Phone: 716 - 375 – 2066

Please give a significant explanation of ***all*** of the above items to which you have answered **YES.**

_____
_____
_____
_____

Student's Name _____
Date of Birth _____/____/_____

NOTICE! IT'S THE LAW! NO SHOTS - NO REGISTRATION

NYS Public Health Law 2165 requires college students to show proof of immunity to measles, mumps, and rubella. Students born prior to 1/1/57 are exempt from this requirement unless required by their academic major to meet clinical placement requirements. If you are exempt you must provide proof of age.

NYS Public Health Law 2167 requires colleges to distribute information about meningococcal disease and vaccination to all students.

REQUIRED NEW YORK STATE IMMUNIZATIONS (MUST INCLUDE MONTH, DAY, AND YEAR)

Copy of Approved Immunization Record Mandatory

1: MMR (Measles, Mumps, and Rubella) Must have either of the following:

1. **Measles** : Dates of *Two* live Measles Vaccines:

OR

Date of positive **Measles** Titer Results:
(Copy of titer results REQUIRED)

2. **Mumps :** Date of at least one live **Mumps** Vaccine:

OR

Date and results of Positive **Mumps** Titer Results:
Copy of titer results REQUIRED.

3. **Rubella:** Date of at least one live **Rubella** Vaccine:

OR

Date of positive **Rubella** Titer Results:
Copy of titer Results REQUIRED.

2: Meningococcal Meningitis :

1. Copy of immunization record of at least one Meningitis vaccine in the past 10 years:

OR

2. Date of at least one Meningitis vaccine in the past 10 years: (1) _____ (2) _____

Student signature_____ ***If student is a minor, parent or guardian signature required*** _____

OR

°Meningococcal Vaccine Fact Sheet may be found at:

http://www.cdc.gov/meningococcal/about/index
http://www.health.state.ny.us/diseases/communicable/meningococcal/fact_ sheet.htm

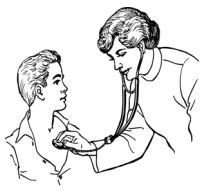
3. I have read the Meningitis information on St. Bonaventure website under Student /Health and Wellness, (listed above) or have had explained to me the information regarding Meningococcal Meningitis disease. **I understand the risk of *NOT having the vaccine.***

I have decided that I (or my child) will NOT obtain the immunization against Meningococcal meningitis disease

Student signature _____ ***Date***_____
If student is a minor, parent or guardian signature required_____ ***Date***_____

*Physical Exam is not required by the state of New York.

*****SBU Health Service Staff encourages students to have PE before coming to campus.***
Your health care provider may use their PE form of choice.



If you intend to play a club sport at SBU, print the ***required clearance form* available at:
http://www.sbu.edu/life-at-sbu/services-for-students/health-wellness
or
http://www.sbu.edu/life-at-sbu/activities-programs/student-activities-recreation-leadership/sports-recreation-fitness/club-sports

Clearance form must be completed by Health Care Provider and returned to the Center for Student Wellness

Student's Name _____
Date of Birth _____/____/_____

TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? □ Yes □ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? □ Yes □ No

(If yes, please circle the country below)

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

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above)

☐ Yes
☐ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?

☐ Yes
☐ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

☐ Yes
☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

☐ Yes
☐ No

*If the answer is **YES** to any of the above questions, St. Bonaventure University requires that you receive TB testing along with

A copy of the results or a copy of your BCG immunizations prior to the start of the subsequent semester.

BCG Date _____ TB Date _____ TB Result _____mm

If the answer to all of the above questions is **NO**, no further testing nor further action is required.

Students Name _____

Date of Birth ____/____/_____

SELF EVALUATION OF LIFESTYLE FACTORS

(To be completed by the applicant)

1. **EXERCISE:** How many times per week do you spend at least 30 minutes in vigorous physical exercise such as biking running, swimming? _____

2. **BODY BASICS**: What is your height? _____FT. _____Inches
   What is your body weight _____lbs.
   Do you consider yourself:
   ( ) underweight ( ) overweight
   By how many pounds? _____

3. **NUTRITION**: Do you eat a balanced diet, including whole grain breads and cereals, fruits, vegetables, protein and carbohydrates?

   _____

   Do you try to limit your intake of fried foods, dairy products, and processed foods which are high in fats and/ or cholesterol?

   _____

4. **TOBACCO USE:** Do you smoke cigarettes? ___ No ___Yes (*If yes*)
   How long have you been a smoker? _____
   How many per day?_____
   Do you chew tobacco?_____
   Are you interested in quitting? _____
   Contact SBU Counseling Services for assistance

5. **ALCOHOL USE**: How often do you drink alcohol?
   ( ) not at all
   ( ) less than once a week
   ( ) once a week
   ( ) 2 or 3 times per week
   ( ) more than 3 times per week

   What is your average alcohol consumption (number (number of shots, 8 oz. beers or 6 oz. glasses of wine) per drinking occasion? _____

   Do *you* believe you may have a problem with alcohol?
   ___ No ___Yes (*If yes*)

   Please consider utilizing The Center for Student Wellness Health and Counseling Services located in Doyle Hall Room 127.

If you have pertinent information you feel the Center for Student Wellness Health Service Department would need knowledge of in order to assist with your health care, please write on the lines below or call 716.375.2310.

_____

_____

_____

_____

_____

SBU Student Signed Consents

PERMISSION FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE

When serious medical problems arise, every effort will be made to reach parents, guardians or spouse. On occasion, we are unable to make this contact.

To avoid delay in treatment, we request that the following statement be signed by a parent, guardian or spouse.

I hereby grant The Center for Student Wellness Department permission to treat and / or hospitalize my son/daughter/spouse/ward in-case of illness or injury.

Signature of Parent or Guardian or Spouse _____ Date ____/____/_____

Relationship to Student _____

NOTE TO NCAA ATHLETES: Your signature authorizes the release of information between the St. Bonaventure University Center for Student Wellness and the Department of Athletics

NCAA Sport _____ Student Athlete Signature _____ Date ____/____/_____

PERMISSION TO RELEASE MEDICAL INFORMATION

I hereby grant permission to St. Bonaventure University's Center for Student Wellness to release information to Campus Security, Residence Life staff, Counseling Services, Club Sports personnel, ambulance personnel, and Olean General Hospital Emergency Department personnel, if needed, in the best interest of my health and safety.

The Center for Student Wellness Health and Counseling Departments may contact me via email or text.

_____ ____/____/_____
Student's Signature Date

_____ ____/____/_____
Parent's Signature IF student is under 18 years of age Date

I, _____ hereby grant permission for the SBU Center for Student Wellness Health Service Department to release information concerning my medical care to the following persons.

_____ _____
Name Parent Name Relationship

_____ _____
Name Parent Name Relationship

_____ _____/_____/_____
Signature of Student Date

DO NOT WRITE BELOW THIS LINE. CENTER FOR STUDENT WELLNESS STAFF ONLY

Reviewed by: Initials _____ Date _____

	MEDICAL HISTORY	NOTIFIED BY		
Measles	Consent	Email	Initials _____ Date_____	Initials _____ Date_____
Mumps	TB Screen/TSpot	In-Person	Initials _____ Date_____	Initials _____ Date_____
Rubella	MD, HCP Signature	Letter	Initials _____ Date_____	Initials _____ Date_____
Meningitis	Insurance Inform	Phone	Initials _____ Date_____	Initials _____ Date_____
Meningitis Response Form		Text	Initials _____ Date_____	Initials _____ Date_____

New York State Public Health Law 2165 and 2167 Completed: CSW Staff Initials _____ Date _____

St Bonaventure University Requirements Completed: CSW Staff Initials _____ Date _____