Welcome to St. Bonaventure University.
We are glad you're here!

The staff of the Center for Student Wellness in Doyle Hall welcomes you to the next step of your life: COLLEGE! We want to make sure you have the best experience possible and that we are able to provide the best CARE possible for you; BUT you have a HUGE role to play in this right now. Read on…

New York State Public Health Laws 2165 and 2167 requires that you provide us with your complete immunization record and submit the meningitis response form (page 4). The required immunization information is located on pages 4 and 5 of this packet. Please submit these forms by:

July 24th, 2017, (Fall Semester) or January 1, 2018, (Spring Semester).

You can submit the **COMPLETED** forms to us by:

1. Faxing them to us at **716-375-7892**.
2. Scanning the completed forms and emailing them to us at **cswsbu@sbu.edu**
3. Mailing them to:

Center for Student Wellness
St. Bonaventure University
127 Doyle Hall, PO Box 2469
St. Bonaventure, NY 14778

4. Bring the completed forms to room 127 in Doyle Hall.

PLEASE DO NOT SUBMIT PHOTOS OF YOUR RECORDS USING YOUR CAMERA.

ATTENTION NCAA ATHLETES: *The mandatory health evaluation forms (pages 1-5) along with your immunization records must be completed and returned to the Center for Student Wellness in DOYLE HALL* ***BEFORE*** *you arrive on campus for any summer camp or before the semester begins.*

ATTENTION VETERANS: *We will temporarily accept proof of honorable discharge, if it was issued WITHIN THE PAST 10 YEARS, until your actual immunization record from the armed services arrives. If an actual health risk incident occurs on campus while waiting for the actual record to arrive, you may be asked to leave campus until the incident abates or your record arrives.*

THANK YOU FOR YOUR PROMPT ATTENTION TO THIS VERY IMPORTANT PART OF YOUR CAMPUS EXPERIENCE!
WE WISH YOU WELL ON YOUR JOURNEY.

Please check when you will be starting and write which year.

____ Fall **Year**: _____

____ Spring _____ Summer

DATE OF BIRTH: MM/DD/YYYY

_____

GENDER:

_____ Male _____ Female

Other: (Specify)_____

St. Bonaventure University

Mandatory Health Evaluations Forms

Fall semester due date: July 24, 2017

Spring semester due date: January 1, 2018

Please return forms to:

St. Bonaventure University

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

SBU Student ID: _____

Check all that apply:

____ Freshman

____ Transfer

____ NCAA Athlete

(NCAA Sport:_____)

____ Club sport athlete

____ Commuter student

NAME: Last _____ First _____ Middle_____

Previous names used (i.e. maiden names, etc):_____

HOME ADDRESS: Street _____ PO Box: _____ City: _____

State/Province:_____ Zip Code: _____ Country:_____

PHONE: Home_____ Cell _____ **EMAIL:** _____

EMERGENCY CONTACT: _____ (Relationship to student) _____

PHONE: Home_____ Cell _____ Business _____

HEALTH CARE PROVIDER: (Doctor, Nurse Practitioner, Physician Assistant)

Name: _____ Phone _____

Address: Street _____ PO Box: _____ City: _____

State/Province:_____ Zip Code: _____ Country:_____

INSURANCE INFORMATION Do you have health insurance? _____ YES _____ NO

Select one: _____ On parent/guardian's policy _____ Individual policy holder ____ Purchased SBU student policy

*Please complete AND **attach a photocopy of insurance card** (front and back of card)

NAME of INSURANCE COMPANY: _____ Phone: _____

Address: _____ City_____ State_____ Zip _____

Policy Holder's Name and Birthdate (If not self): _____MM/DD/YYYY _____

Phone _____ Place of employment _____

Policy ID Number: _____ Group number: _____

PLEASE NOTE: Health insurance is required for all students. If you presently are not covered by health insurance, information for obtaining coverage through the St. Bonaventure Plan is available at: http://www.sbu.edu/life-at-sbu/services-for-students/health-wellness

If you presently have insurance, you will need to opt out of the student policy by signing the waiver found at:

https://www.haylor-college.com/Studenthealth/Selectschool.asp?GroupNumber=37&Waive=1

If you do not sign the waiver, your account will be billed the cost for the student policy for the school year.

Insurance enrollment/waiver open: July 10, 2017.

Student name: _____

Date of birth: MM/DD/YYYY _____

St. Bonaventure University

Center for Student Wellness Emergency Consents

1. Underage Student Care Consent (Only for Parents/Guardians of Students Under 18)

If an urgent or non-urgent medical problem arises, in order to provide care for your child and release information to a parent(s) or guardian(s), the campus medical provider requires consent prior to giving treatment. Therefore, we request the following statement be signed by a parent(s) or guardian(s) for students under 18:

I hereby grant the Center For Student Wellness permission to treat my son/daughter/ward at the Center for Student Wellness Health Services or send my son/daughter/ward to the Urgent Care Center/Emergency Room/Hospital for evaluation/treatment in case of illness or injury.

Name of Student: _____

Signature of Parent(s) or Guardian(s): _____

Date: MM/DD/YYYY _____ Relationship to Student: _____

2. Permission To Release Medical Information To Parents/Guardians

*****(For Students 18 and Over Only)******

I hereby grant permission for the Center for Student Wellness, Health Services Staff, to release medical information to the following parent(s), guardians(s), or personal representative(s). I understand that I may make exceptions to this release for certain types of information by filling in the line below. If the line is left blank, then there will be no exceptions for what types of medical information may be shared to the people listed below. I may make changes to this consent at any time by coming to the Center For Student Wellness and filling out a new consent form.

Parent/Guardian/Representative: _____ Relation to Student: _____

Parent/Guardian/Representative: _____ Relation to Student: _____

Any limitations on issues your healthcare provider at the Center For Student Wellness may discuss with the above listed individual(s)? _____

Signature of Student (18 yrs and older): _____ Date: _____

3. Permission to Release Medical Information To ***Emergency Responders***

(For all students 18 and over.)

I hereby grant permission to the Center For Student Wellness, Health Services Unit, to release information to Campus Security, the Vice President of Student Affairs, the SBU Medical Emergency Response Team (MERT), Counseling Services, Residence Life, Club Sports Personnel, EMS/Ambulance Personnel, and Olean General Hospital Emergency Department Personnel if needed, in the best interest of my health and safety. I acknowledge this release is **only valid in emergency situations where my safety or life is in danger**. I understand that any other release of my personal information will require me to sign the other sections of this consent or third party releases through the Center For Student Wellness.

Student signature: _____Date: MM/DD/YYYY _____

*Student name: _____
Date of birth: _____/_____/_____

PERSONAL HEALTH HISTORY

Check if you have or had any of the following conditions:

____ Eye disorders	____ Anemia	____ MRSA
____ Migraines	____ Blood Clotting Disorder	____ Skin disorders
____ Seizure disorder	____ Liver disease/hepatitis	____ Cancer
____ Concussions	____ Chronic constipation	____ Anxiety
____ Fainting episodes	____ Chronic diarrhea	____ Depression
____ Hearing difficulty	____ Ulcerative colitis/Chrohn's	____ Drug/alcohol issues
____ Thyroid disorders	____ Stomach ulcers	____ Autism spectrum disorder
____ Diabetes (Type 1 or 2)	____ Polycystic ovarian disease	____ Learning disability
____ Asthma	____ Kidney infections	____ Physical handicap
____ Pneumonia	____ Kidney stones	____ Other physical/mental
____ Stroke	____ STD's/STI's	disorders not listed here:
____ Heart murmur	____ Back pain	_____
____ Irregular heart beat	____ Broken bones	_____
____ Congenital heart defect	____ Sprains/dislocations	_____
____ Rheumatic heart disease		
____ High blood pressure		

**If you have a physical or learning disability, please contact the TEACHING AND LEARNING CENTER in PLASSMAN HALL at 716-375-2066 so they can share with you the ways they can support your efforts at St. Bonaventure.

ALLERGIES: Check if you have any of the following:

____ Allergies to medications. If yes, please list here and explain the type of reaction you have experienced:
_____

____ Allergies to foods. If yes, please list here and explain the type of reaction you have experienced:
_____

____ Allergies to other items: (Environmental, seasonal, pets, etc.): If yes, please list here and explain the type of reaction you have experienced: _____

_____

MEDICATIONS: Are you taking any prescribed medications on a regular or intermittent basis?

____ Yes _____ No If yes, please provide name(s) and dosage(s): _____

_____

HOSPITALIZATIONS: Have you ever been hospitalized for an illness or injury? ____ Yes ____ No.
If yes, please provide dates and reasons for hospitalization: _____

_____

CHRONIC HEALTH PROBLEMS: Do you have any chronic health problems for which you are currently under treatment?
_____ Yes _____ No. If yes, please explain: _____

_____

PLEASE READ THIS FORM VERY CAREFULLY

*Student name: _____

*Date of birth: _____/_____/_____

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

New York State Public Health Law 2165 requires college students to show proof of immunity to measles, mumps, and rubella. People born before 1/1/1957 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. New York State Public Health Law 2167 requires colleges to distribute information about meningococcal disease and vaccination to all students.

COPY OF APPROVED IMMUNIZATION RECORDS, REQUIRED BY NEW YORK STATE
(Must include student's name, month, day, and year of all vaccinations.)

1. **2 (two) MMR shots (MEASLES, MUMPS, RUBELLA) as combined vaccinations. IF RECEIVING VACCINATIONS SEPARATELY,**
   - Measles: Documentation of two (2) live measles vaccines
   - Mumps: Documentation of at least one (1) live mumps vaccine
   - Rubella: Documentation of at least one (1) live rubella vaccine

OR

***A copy of a positive MMR titer result.**

2. **Meningococcal/Meningitis: PUT AN "X" ON THE LINE FOR THE CHOICE YOU ARE PROVIDING. If you are unsure, please consult your doctor.**
   a. _____Documentation of at least one (1) meningitis (ACWY) vaccine received within the past 5 years.

   OR

   b. _____Documentation of a completed two (2) or three (3) dose series of Men B vaccine

   OR

   c. _____ You may check this option (c) if you have an appointment to receive one of the above (a or b) meningitis vaccine options **within 30 days** of arrival on campus.

   OR

   d. _____VACCINE REFUSAL WAIVER (BELOW): Please read the **meningococcal vaccine fact sheet found at: https://www.health.ny.gov/publications/2168/**

IMPORTANT NOTE: The St. Bonaventure Health Services Unit does NOT provide meningococcal/meningitis vaccines. If you are planning on getting the vaccine but have not yet done so, please consult with your physician or your local county health department prior to arrival on campus. You may get the vaccine locally at the Cattaraugus County Dept. of Health at: 1 Leo Moss Drive, #4010, Olean, NY 14760. The approximate costs as of April 2017 of the available vaccines choices are:
Menvio: $113
Men B series (x2): Approx. $165 per dose.

"I have read the meningitis information found at the above website or on the St. Bonaventure University Health Services web page, or I have had the information explained to me by a professional health care provider regarding meningococcal disease (meningitis). I understand the risks of NOT having the vaccine. I have decided that I (or my child, for students under the age of 18) will NOT obtain the immunization against meningococcal disease (meningitis) at this time."

Student signature (if 18 or over): _____ Date_____

Parent signature (for students under 18): _____ Date: _____

NOTES ON STUDENT PHYSICALS and STUDENT ATHLETES: In general, St. Bonaventure University does not require a physical, although one may be required for sports, extracurricular activities, or other campus programs. A ***Sports Clearance Form*** must be completed by your health care provider and returned to the Center for Student Wellness, Health Services Unit, in order to be eligible to play club sports. ***NCAA students:*** You have separate forms provided by your team. Please consult your respective coaching staff and managers for these forms. The club sports forms may be found at: http://www.sbu.edu/life-at-sbu/services-for-students/health-wellness

***MEDICAL/RELIGIOUS EXEMPTIONS from vaccinations require a written statement of explanation signed by a physician for medical exemptions or a written explanation of genuine and sincere beliefs contrary to the practice of immunization for religious exemptions.**
***STUDENTS WAIVING VACCINATIONS: Any student waiving vaccinations for any reason will be asked to leave campus if an outbreak occurs until the situation is resolved.**

*SBU Student Name: _____

Date of Birth: MM/DD/YYYY _____

Tuberculosis (TB) Screening

Please answer the following questions:

Have you ever had close contact with a person who was known or suspected to have active tuberculosis (TB)?

_____ Yes _____ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease?

_____ Yes (If yes, please circle the country below.) _____ No

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

Have you had frequent or prolonged visits to one or more of the countries or territories listed above with high prevalence of TB?

_____ Yes (If YES, Place an "X" next to each visited.) _____ No

If you **answered YES and put an "X" to ANY of the above countries**, please write the date(s) of exposure or visit(s) on the line below.

_____

Have you been a resident and/or employee of high-risk setting(s) (i.e. 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 substance abusing groups? _____Yes _____ No

If you answered **"NO" TO ALL** of the above questions on Page 5: **STOP HERE. You do NOT need to fill out pages 6 and 7.**

If you answered **"YES" to ANY** of the above questions on Page 5: **TAKE THIS FORM along with PART II and PART III (Pages 6 and 7)** of the TB Screening TO YOUR HEALTHCARE PROVIDER to be filled out.

UNDERGRADUATE USE ONLY. COMPLETE PART II AND PART III ONLY IF ANSWERED "YES" TO ANY QUESTIONS ON PAGE 5.

*SBU Student Name: _____
Date of Birth: MM/DD/YYYY _____

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes _____ No _____**

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes _____ No _____**

---

1. Does the student have signs or symptoms of active pulmonary tuberculosis disease?
Yes _____ No_____ If No *Proceed to 2 or 3

If yes, check below:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis),❑ Chest pain,❑ Loss of appetite,❑ Unexplained weight loss,
- ❑ Night sweats,❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

(Part II continued on next page.)

UNDERGRADUATE USE ONLY. COMPLETE PART II AND PART III ONLY IF ANSWERED "YES" TO ANY QUESTIONS ON PAGE 5.

*SBU Student Name: _____
Date of Birth: MM/DD/YYYY _____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y
Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y
Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Part III. Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

••Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

_____Student agrees to receive treatment _____Student declines treatment at this time

_____ _____
Health Care Professional Signature Date

_____ _____
Health Care Professional Printed Name Health Care Professional Phone Number

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