

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 page 4 of this packet. **WE MUST HAVE THIS INFORMATION ON FILE BY:**

July 23, 2018, for students starting in the fall 2018 semester.

January 3, 2019, for students starting in the spring 2019 semester.

PLEASE check with your primary care provider or your high school for copies of your immunization record.

Submit your immunization records and the forms below to us using one of the methods below:

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** at SBU.

***** PHOTOS OF YOUR RECORDS USING YOUR CAMERA ARE NOT ACCEPTABLE AND YOU WILL BE ASKED TO RESUBMIT THEM USING ONE OF THE METHODS ABOVE.*****

ATTENTION NCAA ATHLETES: *The mandatory health evaluation forms below along with your official immunization record 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. For additional assistance in securing military immunization records, please contact Frank Morales, Director of Veterans Services at 716-375-2105.*

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 23, 2018

Spring semester due date: January 3, 2019

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 _____

Relation to policy holder (if not self): _____ 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 9, 2018.

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:

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

These forms need to be completed and returned to the Center for Student Wellness.

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.

PLEASE PROVIDE A COPY OF APPROVED IMMUNIZATION RECORDS, AS 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: PLEASE CHECK THE LINE FOR THE CHOICE YOU ARE PROVIDING.

a. _____ I received the meningococcal (meningitis) immunization within the **past 5 years.**

OR the option below in the box:

b. _____ I am choosing to NOT RECEIVE the meningitis vaccine at this time. Please read the **meningococcal vaccine fact sheet found at:**

<https://www.health.ny.gov/publications/2168/>

"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."

****SIGNATURE NEEDED ONLY IF YOU ARE REFUSING THE MENINGITIS VACCINATION****

Signature (Students 18 and over OR parent): _____ Date _____

***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 (for resident students) or remain off campus (commuter students) if an outbreak occurs until the situation is resolved.**

IMPORTANT NOTE: The St. Bonaventure Health Services Unit DOES NOT PROVIDE the 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.