Welcome to St. Bonaventure University!

The staff of the Center for Student Wellness in Doyle Hall welcomes you to St. Bonaventure. We want to make sure you have the best experience possible and that we are able to provide the best CARE possible for you as needed. In order to do so, and to be compliant with NYS law, we need a few things from you.

New York State Public Health Laws 2165 and 2167 requires that you provide us with your complete immunization record. The required immunization information is located on pages 2-3 of this packet. You need to have this information to us by:

- **30 days after the first day of classes for New York residents;**
- **45 days after the first day of classes for out of state and international students.**

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

1. Faxing them to The Center For Student Wellness 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. Bringing the completed forms to the Graduate Admissions Office, second floor of Hopkins Hall, or to the Center for Student Wellness, room 127 in Doyle Hall.

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

PLEASE NOTE: ***Immunizations may be provided by a medical office, or may be a copy of records you possess that include the name of the clinic or office providing them and bear a copy providers original signature. Note that many grad students are able to have their undergraduate college send immunization records. If you were an undergraduate student recently, please try this first as it is often the most convenient way to obtain them.***

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 GRADUATE SCHOOL EXPERIENCE! WE WISH YOU WELL ON YOUR JOURNEY. –The Center for Student Wellness Staff

GRADUATE STUDENT USE ONLY

St. Bonaventure University

GRADUATE STUDENT

HEALTH FORMS

GRADUATE STUDENT USE ONLY

Due 30 days after start of classes (NY residents)

Due 45 days after start of classes (Non-NY residents/International Students).

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

_____ Fall **Year**: _____

_____ Spring

_____ Summer

Other: (please specify)

If you previously attended SBU, please specify which term and year: _____

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: _____

GENDER:

_____ Male _____ Female

Other: (Specify)_____

DATE OF BIRTH: MM/DD/YYYY

_____

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 _____

Permission To Release Medical Information (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, 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 a third party release through the Center For Student Wellness.

Student signature: _____Date: MM/DD/YYYY _____

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

Select one: _____ On parent/guardian/spouse policy _____ Individual policy holder____ Purchased SBU student policy

PLEASE NOTE: Health insurance is required by law for everyone. If you presently are not covered by health insurance and are taking at least 6 credits, you may purchase the SBU student policy. 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 are interested in using the campus Center for Student Wellness Health Services, you may do so for a charge of $55 per semester. This amount is not prorated, so if you decide to start using campus Health Services, you will need to pay $55 regardless of when during the semester you decide to pay. This charge only covers campus Health Services. If you opt in to use campus Health Services, there will be additional health information forms for you to fill out. Please contact the Bursar's office for additional information at 716-375-2030 or the Center for Student Wellness at 716-375-2310. Thank you.**

GRADUATE STUDENT USE ONLY

*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. 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: 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_____

***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.**

GRADUATE STUDENT USE ONLY

GRADUATE STUDENT USE ONLY

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

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 _____ No (If YES, Place a CHECK MARK next to each visited.)

Have you been a resident and/or employee of high-risk congregate settings (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 **checked YES to ANY of the above countries**, please write the dates of exposure or visits on the line below.

_____

*If the answer is YES to any of the above **QUESTIONS**, you will be required to 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 is **NO** to all of the above questions, then no further testing nor action is required at this time.