WELCOME TO ST. BONAVENTURE !!!

The St. Bonaventure Center for Student Wellness joins in welcoming you to your extraordinary experience at St. Bonaventure University. We are part of the Student Life Division. Our goal is to help you to stay physically and emotionally healthy and to receive appropriate care when needed. We look forward to becoming a partner in your health related issues while you are a SBU student.

This letter includes information we will need you to complete and return to our department in order to provide these services.

**Before July 25th 2015 Mandatory Health Evaluation Forms: pages 1-5 must be completed and returned to:**
St. Bonaventure University
The Center for Student Wellness, 127 Doyle Hall
PO Box 2469
St. Bonaventure, New York 14778
Email: mbova@sbu.edu
Phone: 716-375-2310
Fax: 716-375-7892

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

If you have any questions or concerns with completion of the forms, please do not hesitate to call the Center for Student Wellness using the information listed above.

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 at 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 using www.haylor-college.com. preferably by the start of classes, otherwise it will be billed to your SBU account.*

**Verification options of requested immunization:**
Measles, Mumps and Rubella
1.) Official immunization records signed or stamped by Health Provider or High School immunization records documenting 2 MMR’s
2.) Serological Titer to prove immunity of MMR

**Please note: TITER REPORT MUST BE SIGNED BY ORDERING A HEALTH CARE PROVIDER**

Meningococcal Meningitis
1) Official documentation of Meningococcal Meningitis Vaccine or Meningitis Waiver completed and signed by student.

**Meningococcal Vaccine Fact Sheet** may be found at:
http://www.cdc.gov/ meningococcal/about/index.html as well as
http://www.health.state.ny.us/diseases/communicable/ meningococcal/fact_sheet.htm

**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) must follow promptly.

**NCAA Student Athletes:** The Athletic Department will coordinate your physical exam. The Mandatory Student Health Evaluation Forms / immunization Records are still Required to be completed and returned to Health Services by July 15, 2015.

We greatly appreciate your assistance with completion of these forms in a timely manner. Welcome to St. Bonaventure University and on behalf of the Center for Student Wellness. We look forward to meeting you soon!

Roger Keener, Ed.D, Director
St. Bonaventure University
Center for Student Wellness
St. Bonaventure University
Mandatory Health Evaluation Forms
and
Immunizations for Undergraduate Students
(6 credit hours or more)

Forms due:
Fall Semester: July 25, 2015
Spring Semester: January 1, 2015

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: mbova@sbu.edu

Please check one:
___ Fall Semester Year _____
___ Spring Semester Year ______
___ Summer Semester Year _____

Check All that Apply
___ Freshmen
___ Transfer
___ Athlete
   Sport__________
___ Residential Student
___ Commuter

Date of Birth__/__/____
Gender: Male ______
   Female ______

Please Print or Type
Name  Last ___________________________________________ First  __________________________ Middle _________________
Home Address Street __________________________________ City  __________________ State  ________ Zip  ______________
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 Information:
1) Are you covered by health insurance? (    ) yes  (    ) no
   (    ) Covered through parent or family policy  (    ) Individual policy holder
2. Please complete the information below or 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 _____________
# Personal Health History

**Students Name ________________________________**

**Date of Birth _____/_____/_______**

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

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ( ) ( ) Vision Difficulty, Eye Disorders</td>
<td>20. ( ) ( ) Blood Clotting Disorder</td>
</tr>
<tr>
<td>2. ( ) ( ) Ear Trouble/ Hearing difficulty</td>
<td>21. ( ) ( ) Anemia</td>
</tr>
<tr>
<td>3. ( ) ( ) Seasonal Allergies</td>
<td>22. ( ) ( ) Diabetes</td>
</tr>
<tr>
<td>4. ( ) ( ) Chronic Sinusitis</td>
<td>23. ( ) ( ) Constipation</td>
</tr>
<tr>
<td>5. ( ) ( ) Thyroid Disorders</td>
<td>24. ( ) ( ) Stomach Ulcers</td>
</tr>
<tr>
<td>6. ( ) ( ) Repeated Ear Infections</td>
<td>25. ( ) ( ) Chronic Diarrhea</td>
</tr>
<tr>
<td>7. ( ) ( ) Pneumonia</td>
<td>26. ( ) ( ) Ulcerative Colitis/Crohn's</td>
</tr>
<tr>
<td>8. ( ) ( ) Mono</td>
<td>27. ( ) ( ) Liver Disease/Hepatitis</td>
</tr>
<tr>
<td>9. ( ) ( ) Asthma</td>
<td>28. ( ) ( ) Kidney Disorders</td>
</tr>
<tr>
<td>10. ( ) ( ) Irregular Heart Beat</td>
<td>29. ( ) ( ) Bladder Infections</td>
</tr>
<tr>
<td>11. ( ) ( ) Congenital Heart Defect</td>
<td>30. ( ) ( ) Pelvic Infection/Pain</td>
</tr>
<tr>
<td>12. ( ) ( ) Heart Murmur</td>
<td>31. ( ) ( ) Irregular Menstrual</td>
</tr>
<tr>
<td>13. ( ) ( ) Rheumatic Heart Disease</td>
<td>32. ( ) ( ) Irregular Heart Beat</td>
</tr>
<tr>
<td>14. ( ) ( ) Heart Disease (under age 50)</td>
<td>33. ( ) ( ) Hemia</td>
</tr>
<tr>
<td>15. ( ) ( ) High Blood Pressure</td>
<td>34. ( ) ( ) Pilonidal Sinus/Cyst</td>
</tr>
<tr>
<td>16. ( ) ( ) Repeated Strep Infections</td>
<td>35. ( ) ( ) Skin Disorders: (Please Circle)</td>
</tr>
<tr>
<td>17. ( ) ( ) Tooth /Gum Disease</td>
<td>36. ( ) ( ) Other ____________________</td>
</tr>
<tr>
<td>18. ( ) ( ) Stroke</td>
<td>37. ( ) ( ) MRSA</td>
</tr>
<tr>
<td>19. ( ) ( ) Seizure disorder</td>
<td>38. ( ) ( ) Cancer</td>
</tr>
<tr>
<td>20. ( ) ( ) Heart Murmur</td>
<td>39. ( ) ( ) Rheumatoid Arthritis</td>
</tr>
<tr>
<td>21. ( ) ( ) Back problems</td>
<td>40. ( ) ( ) Broken Bones</td>
</tr>
<tr>
<td>22. ( ) ( ) Pilonidal Sinus/Cyst</td>
<td>41. ( ) ( ) Sprains /Dislocations</td>
</tr>
<tr>
<td>23. ( ) ( ) Ulcerative Colitis/Crohn's</td>
<td>42. ( ) ( ) Concussion</td>
</tr>
<tr>
<td>24. ( ) ( ) Back problems</td>
<td>43. ( ) ( ) Other physical disorders</td>
</tr>
<tr>
<td>25. ( ) ( ) Other physical disorders</td>
<td>44. ( ) ( ) Fainting episodes</td>
</tr>
<tr>
<td>26. ( ) ( ) Liver Disease/Hepatitis</td>
<td>45. ( ) ( ) Seizure disorder</td>
</tr>
<tr>
<td>27. ( ) ( ) Kidney Disorders</td>
<td>46. ( ) ( ) Migraine headaches</td>
</tr>
<tr>
<td>28. ( ) ( ) Bladder Infections</td>
<td>47. ( ) ( ) Other physical disorders</td>
</tr>
<tr>
<td>29. ( ) ( ) Irregular Menstrual</td>
<td>48. ( ) ( ) Alcoholism</td>
</tr>
<tr>
<td>30. ( ) ( ) Pelvic Infection/Pain</td>
<td>49. ( ) ( ) Drug dependency</td>
</tr>
<tr>
<td>31. ( ) ( ) Irregular Heart Beat</td>
<td>50. ( ) ( ) Depression</td>
</tr>
<tr>
<td>32. ( ) ( ) Hemia</td>
<td>51. ( ) ( ) Anxiety</td>
</tr>
<tr>
<td>33. ( ) ( ) Heart Murmur</td>
<td>52. ( ) ( ) Eating Disorder</td>
</tr>
<tr>
<td>34. ( ) ( ) Pilonidal Sinus/Cyst</td>
<td>53. ( ) ( ) Other Psychological</td>
</tr>
<tr>
<td>35. ( ) ( ) Skin Disorders: (Please Circle)</td>
<td>54. ( ) ( ) Other Psychological</td>
</tr>
<tr>
<td>36. ( ) ( ) Other ____________________</td>
<td>55. ( ) ( ) Other Psychological</td>
</tr>
</tbody>
</table>

- **Allergies to Medications**: Please list name of medications and type of reaction:

- **Environmental allergies**: Please list

- **Food allergies**: Please list:

- **Chemical or contact substances**:

- **Others**: Please list:

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

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61. ( ) ( ) Are you currently taking any prescribed medication on a regular or intermittent basis?

Name of medication and dosage: ____________________________

Condition for which it is prescribed: ____________________________

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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 a learning disability with which we can assist you?

*If yes, contact, The Teaching and Learning Center in Doyle Hall, Phone: 716-375-2066.

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*Students Name ________________________________

**Date of Birth _____/_____/_______**

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Rev.mb4/27/15

Page 2

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Immunization Requirements

Immunizations are needed for students born after 1956 that are taking 6 or more credit hours.

*Records indicating proof of the immunizations listed below must be submitted with this health form.*

*Attach photocopy of signed or stamped physician or clinic records and/or school immunization certificate listing dates of immunizations.*

Meningococcal Meningitis Vaccine

1) Official documentation of Meningococcal Meningitis Vaccine **MUST HAVE BEEN RECEIVED IN THE PAST 10 YEARS**

Optional: Meningitis Waiver

I HAVE REVIEWED THE FACT SHEET REGARDING MENINGOCOCCAL DISEASE. I AM FULLY AWARE OF THE RISKS ASSOCIATED WITH THIS DISEASE AND OF THE AVAILABILITY AND EFFECTIVENESS OF THE VACCINE. I DECLINE THE VACCINE AT THIS TIME.

Signature of Student ___________________________ Date _____/_____/______ (parent or guardian signature if under age of 18)

Last Tetanus Vaccine Date _____/_____/_____

**Td Booster needs repeated every 10 years**

PPD Date within 1 Year _____/_____/_____

( ) positive ( ) negative

Results to be read within 48-72 hours ________mm induration

Date BCG given _____/_____/______

Communicable Disease History

Please indicate if you have had any of the following diseases and at what age you had the disease.

<table>
<thead>
<tr>
<th>NO</th>
<th>UNCERTAIN</th>
<th>YES</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>Measles (9 day)</td>
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<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>German Measles</td>
</tr>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>Rubella (3 day)</td>
</tr>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>Mumps</td>
</tr>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>Chickenpox</td>
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<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>Whooping Cough</td>
</tr>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>Diphtheria</td>
</tr>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>Polio</td>
</tr>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>Tuberculosis</td>
</tr>
</tbody>
</table>

Family Health History

Please indicate if any of your blood relatives (parents, brothers, sisters, children, grandparents, have had any of the following:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>RELATIONSHIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Stroke</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Asthma</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Thyroid problems</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Gout</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Obesity</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Alcoholism/Drug</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Cancer</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Allergies</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Other Mental Illnesses</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>
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, or 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 butter, eggs, fried foods and dairy products which are high in fats and/ or cholesterol? __________________________________________________________________________________________

4. **TOBACCO USE:**
   - Do you smoke cigarettes? ________
   - How many per day? ________
   - How long have you been a smoker? ________
   - Do you chew tobacco? ________
   - Are you interested in quitting? ________
   - (Counseling is available in Health Services to quit tobacco.)

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 of shots, 8 oz. beers or 6 oz. glasses of wine) per drinking occasion? __________________________________________________________________________________________
   - Do you believe you may have a problem with alcohol? __________________________________________________________________________________________
   - (Counseling is available with SBU Counseling Services in Doyle Hall room 127)
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 permission to treat and/or hospitalize my son/daughter/spouse/ward incase of illness or injury.

Signature of Parent or Guardian or Spouse _______________________________ Date __/__/____
Relationship To Student __________________________________________

** Note to Athletes: Your signature authorizes the release of this information between the Center for Student Wellness and the athletic training staff at St. Bonaventure University.

Student Athlete Signature _______________________________ Date __/__/____

PERMISSION TO RELEASE MEDICAL INFORMATION

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

_____________________________________________                          __/__/________
Student’s Signature                                                                 Date

______________________________________________                       __/__/________
Parent’s Signature IF student is under 18 years of age                                    Date

I __________________________________ hereby grant permission for the Center for Student Wellness Health Service Department at St. Bonaventure University to release information concerning my medical care to the following persons.

Name                                         Parent
_________________________________________                                                              ______________________
Name                                         Parent
_________________________________________                                                              ______________________
Name                                         Relationship
__________________________________________                                                 _________/_______/______
Signature of Student                                                                         Date

Page 5
Rev.mb4/27/15