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’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.

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
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

Please check one:
___ Fall Semester Year _____
___ Spring Semester Year _____
___ Summer Semester Year _____
___ Former SBU Student (last Semester attended) _________

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):

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 Information

1.) 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 IDENTIFICATION 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
## Personal Health History

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

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
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</thead>
<tbody>
<tr>
<td>1. ( ) ( ) Eye Disorders</td>
<td>20. ( ) ( ) Blood Clotting Disorder</td>
</tr>
<tr>
<td>2. ( ) ( ) 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. ( ) ( ) Pilonidal Sinus/Cyst</td>
</tr>
<tr>
<td>14. ( ) ( ) Heart Disease (under age 50)</td>
<td>33. ( ) ( ) Hernia</td>
</tr>
<tr>
<td>15. ( ) ( ) High Blood Pressure</td>
<td>34. ( ) ( ) Skin Disorders: (Please Circle)</td>
</tr>
<tr>
<td>16. ( ) ( ) Repeated Strep Infections</td>
<td>35. ( ) ( ) 【Eczema/Psoriasis/ Severe Acne】</td>
</tr>
<tr>
<td>17. ( ) ( ) Tooth /Gum Disease</td>
<td>Other __________________</td>
</tr>
<tr>
<td>18. ( ) ( ) Stroke</td>
<td>36. ( ) ( ) Autism Spectrum Disorder</td>
</tr>
</tbody>
</table>

**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:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**56. ( ) ( ) 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:

________________________________________________________________________

**61. ( ) ( ) Have you ever been hospitalized for an illness or injury?**

Date/Year ___/____/_____ Reason for hospitalization ______________________________________

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

________________________________________________________________________

**63. ( ) ( ) 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

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
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 ________________________________ 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
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       Iran (Islamic Republic of)       Namibia       Solomon Islands
Algeria          Iraq                        Nauru         Somalia South Africa
Angola           Kazakhstan                  Nepal         South Sudan
Anguilla         Kenya                       Nicaragua      Sri Lanka
Argentina        Kyrgyzstan                  Niger         Sudan
Armenia          Lao People's Democratic     Nigeria        Suriname
Azerbaijan       Republic                   Pakistan       Swaziland
Bangladesh       Latvia                      Palau         Tajikistan
Belarus          Lesotho                     Panama         Thailand
Belize           Liberia                      Paraguay       Timor-Leste
Benin            Libya                       Peru          Togo
Bhutan           Lithuania                   Philippines    Trinidad and Tobago
Bolivia (Plurinational State of)       Madagascar      Poland        Tunisia
Bosnia and Herzegovina       Malawi                     Portugal       Turkmenistan
Botswana          Malaysia                    Qatar         Tuvalu
Brazil           Mali                        Republic of Korea       Republic of Moldova
Brunei Darussalam       Marshall Islands      Romania        Uruguay
Bulgaria          Mauritania                   Russian Federation       Uzbekistan
Burkina Faso      Mauritius                    Rwanda         Vanuatu
Burundi           Mexico                      Saint Vincent and the Grenadines     Venezuela (Bolivarian Republic of)
Cabo Verde        Micronesia (Federated States of)       Viet Nam
Cambodia          Mongolia                    Sao Tome and Principe       Yemen
Cameroon          Montenegro                   Senegal        Zambia
Central African Republic       Morocco                    Serbia
 Chad            Mozambique                   Seychelles       Zimbabwe
China, Hong Kong SAR       Namibia                    Singapore
China, Macao SAR       Nepal                      **Saudi Arabia**
Colombia          Nepal
Comoros

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.
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)
   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? ___ 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

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

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

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

Reviewed by:   Initials ________________               Date _______________________________________

Medical History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Consent</th>
<th>Email</th>
<th>Initials</th>
<th>Date</th>
<th>Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<td>Rubella</td>
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<td>Meningitis</td>
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<tr>
<td>Meningitis Response Form</td>
<td>Insurance Inform</td>
<td>Phone</td>
<td>Initials</td>
<td>Date</td>
<td>Initials</td>
<td>Date</td>
</tr>
</tbody>
</table>

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

St Bonaventure University Requirements Completed: CSW Staff Initials ____ Date ______