



**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 (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 3: **STOP HERE. You do NOT need to fill out any additional forms.**If you answered "YES" to ANY questions on Page 3, **take this page and Parts II and III**, available at Doyle Hall Room 127, by calling 716-375-2310, or on the graduate website at: <http://www.sbu.edu/admission-aid/graduate-admissions> to your healthcare provider to be filled out.