St. Bonaventure University
Center for Student Wellbeing
Health Services
Phone: 716-375-2310 / Fax: 716-375-7892

Box 2469
3261 West State Road
St. Bonaventure, NY 14778

PERSONAL/FAMILY HEALTH HISTORY AND MENINGITIS RESPONSE FORM

For the student: Please complete the following form. It does not need to be signed by your primary care physician.

_____, _____, _____ / _____ / _____
Last Name First Name Middle Name Birthdate

_____ _____
Home Address (Street & No.) City/Town State Zip Gender

Student's preferred name/nickname:_____ **Students** Phone #:_____ Email: _____

Emergency Contact Full Name:_____ Relationship:_____ Contact Phone #: _____

Do you take any medications daily: Yes or No
If yes, list below: medication name, dosage, and for what condition this is taken (ex: Claritin, 10 mg daily for seasonal allergies) If you need additional room, please list on a separate sheet and attach with form.

_____
_____
_____
_____

Have you ever had any of the following: Yes or No

Asthma _____ Diabetes _____ Epilepsy _____ Hospitalization _____
Have you ever been diagnosed with COVID-19, if yes please list date in area below _____

If "Yes" to any of the above, please specify: _____

Do you have any special dietary needs, restrictions or allergies? If allergies please specify reaction: _____
_____
_____

If so, yes to the above do we have your permission to share these needs/restrictions with dining services to ensure that options are available to fit your needs?

☐ Yes ☐ No ☐ Not Applicable

Do you have a family doctor, or other primary healthcare provider such as a physician assistant or nurse practitioner? Y N

If yes please provide your medical providers information below:

Name: _____ Address: _____
_____

Phone Number: _____

Do you have any additional physicians/health care providers, such as specialists, that you see on a regular basis? If so, please provide their name(s) in the space provided:

_____
_____
_____

"I give consent for the medical staff of St. Bonaventure Health Services to contact my primary care physician and/or other medical providers listed above, for the purpose of exchanging medical information that may be required for providing me with the best possible healthcare while I am a student or employee at St. Bonaventure University. I understand that this consent may be revoked at any time by writing to the Director of the Center for Student Wellbeing"

Student Signature:_____ **Date:** _____

FAMILY MEDICAL HISTORY: To help us understand any special circumstances, we need to know if any immediate family members (parents/grandparents/siblings/children) has had any of the following. Please check yes to any that apply and if yes please specify relationship (mother/father…)

Blood Diseases: Y N _____

Cancer: Y N _____

Diabetes: Y N _____

Seizure Disorder: Y N _____

Heart Disease: Y N _____

High Blood Pressure: Y N _____

Kidney Disease: Y N _____

Respiratory Disease: Y N _____

HEALTH SERVICES/COUNSELING SERVICES CONSENT

By signing here, I understand that the Center for Student Wellbeing is an integrated center (health and counseling services) with a shared electronic health record and information may be shared about me between providers for the purpose of collaboration, evaluating needs and providing services. This authorization may include disclosure of information related to alcohol and drug abuse or mental health treatment. I understand this authorization is voluntary and I may revoke this authorization at any time in writing except to the extent that action has already taken place. This authorization does not authorize The Center for Student Wellbeing to discuss my counseling information or medical care with anyone outside of the Center.

Student Signature:_____ **Date:** _____

PREFERRED PHARMACY:

All SBU students will have the closest pharmacy listed as their pharmacy of choice (Wal-Mart Olean, 2-minute drive from campus) unless you designate another preferred pharmacy. As some medical insurances do have a "preferred pharmacy" Are you ok with having Olean Wal-Mart pharmacy listed as your preferred pharmacy? YES NO

If no, please list preferred pharmacy name and address: _____

_____

_____

MENINGITIS VACCINATION RESPONSE FORM

Please read the enclosed information regarding meningitis and the availability of a preventative vaccine.
Note that NYS Public Health Law 2167 requires you to complete the following section in the absence of vaccination.

If you have chosen to decline the Meningitis vaccine, please check the box below and sign on the line indicated.

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease. I understand that although I have declined the vaccine at this time, I have the right to request the vaccine at any time in the future. I understand that in the event of an outbreak of disease that I am not protected against, New York State Public Health Law may require that I be excluded from all classes and campus activities until the risk of contracting the disease is over.

Student Signature (Parent, if under 18)_____**Date:**_____

Student Name (print)_____**Date of Birth**_____**Student ID**_____

If you have received the Meningitis vaccine, this MUST have been within the last five years and documentation must be provided, using the guidelines outlined in the SBU Immunization Policy for proof of vaccination.

St. Bonaventure University
Center for Student Wellbeing

Dear Student/Parent,

As the Medical Director at St. Bonaventure University, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. New York State Public Health Law (NYS PHL) §2167 requires institutions,including colleges and universities, to distribute information about meningococcal disease and the available vaccine to all students meeting the enrollment criteria, whether they live on or off campus.

St. Bonaventure University is required to maintain a record of the following for each student:

- A vaccine record indicating at least 1 dose of meningococcal ACWY vaccine (Menactra, Menveo or MenQuadfi) **within the last 5 years** or a complete 2- or 3-dose series of MenB (Bexsero or Trumenba) without a response form; or
- A signed response form with a vaccine record (If a student submits a response form selecting this option, a vaccine record must be attached); or
- A signed response form indicating that the student will obtain meningococcal vaccine within 30 days; or
- A signed response form indicating that the student will not obtain immunization against meningococcal disease.

If the student has not received meningococcal vaccine within the past 5 years, then they must submit the signed response form.
Students who met the requirements for PHL 2167 in a semester/trimester prior to Spring 2017 do not need to resubmit their vaccine record or their response form.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease cancause serious illnesses such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacterium that causes meningococcal disease even before they know they are sick. There have been several outbreaks of meningococcal disease at collegecampuses across the United States.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause about two-thirds of meningococcal disease in the United States. The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series. They should discuss the MenB vaccine with a healthcare provider.

All private insurance plans not grandfathered under the Affordable Care Act are required to cover the cost of MenACWY and MenB vaccines. Contact your health insurance plan to determine whether it covers MenACWY and MenB vaccines. The federal Vaccines for Children (VFC) and NYS Vaccines for Adults (VFA) programs will cover both MenACWY and MenB vaccines for children and adults who have no health insurance or whose health insurance does not cover these vaccines, as well as for children less than 19 yearsof age who are American Indian or Alaska Native or eligible for Medicaid or Child Health Plus.

While St. Bonaventure University Health Services does not offer meningococcal vaccines, we can assist in a referral to the Cattaraugus County Health Department Immunization Clinic who does offer them or you should consult your primary care provider.

On the Health History Form, complete the meningococcal vaccination response form only if you decide not to receive the vaccine prior to arrival on campus.

To learn more about meningococcal disease and the vaccine, please feel free to contact our health service and/or consult yourphysician. You can also find information about the disease on the Centers for Disease Control and Prevention website at www.cdc.gov/meningococcal/.

Sincerely,

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PHYSICAL FORM: To be completed by the **Healthcare Provider**: **Student ID # _____**

Date of Exam:_____ Name of Student: _____

HGT:_____ WGT:_____ Temperature:_____ B/P:_____/_____ Pulse_____

Allergies (include medication/food/bee sting allergies): _____

Current Medications (prescription/over the counter): _____

Vision: ☐ No Lenses ☐ Lenses R: 20/_____ L: 20/_____

If there is a significant health issue that is important for us to be aware of, please describe on a separate sheet and attach.

Check Each Item in Proper Column: (Enter NE if not evaluated)

	Normal	Abnormal	Comments
1. Nose and Sinuses			
2. Mouth and Throat			
3. Teeth and Gingiva			
4. Ears			
5. Eyes			
6. Pupils and Ocular Motion			
7. Lungs, Chest, Breasts			
8. Heart			
9. Vascular System (Varicosities, etc.)			
10. Abdomen and Viscera (include hernia)			
11. Genital (if appropriate)			
12. Ano-rectal (pilonidal)			
13. Endocrine System			
14. G-U System			
15. Upper Extremities (strength, ROM)			
16. Feet			
17. Lower Extremities			
18. Spine, other musculo-skeletal			
19. Skin & Lymphatics			
20. Neurologic			
21. Psychiatric (specify)			

Is there loss or seriously impaired function of any limb or organ? ☐ Yes ☐ No If Yes, Please Explain:_____

Are there any restrictions of physical activity indicated by your exam? ☐ Yes ☐ No If Yes, Please Explain:_____

Is the student now under treatment for any medical or emotional problem? ☐ Yes ☐ No If Yes, Please Explain: _____

I have examined the above-named student and it is my professional opinion that the student is physically and psychologically able, except as noted above, to undertake college studies.

Examining Healthcare Provider Signature:_____ **Print Name:**_____

Address/City/State/Zip:_____ **Phone:**_____ **Fax:** _____

St. Bonaventure University Center for Student Wellbeing

Authorization Form for Medical Treatment and/or Counseling

Please only complete this form if your child will be **under the age of 18 years while on campus**:

Student Name:_____Student DOB:_____Student ID#:_____

Person to notify in the event of an emergency: _____

As the parent/guardian of_____(print student's name), I hereby authorize the medical and counseling staff of St. Bonaventure University Center for Student Wellbeing, to evaluate, advise, perform any diagnostic procedure (on-site or via referral), and/or provide treatment/counseling as deemed advisable and is under the supervision of a licensed medical provider/licensed mental health counselor. I understand that until the student is 18 years of age, I have a right to be informed of this care, except under certain circumstances as prescribed by the Medical Practice Act. At the time the student turns 18 years old, he/she will be able to consent to his/her own care and this authorization will no longer apply.

Parent/Guardian Name:

(Print)_____(Signature) _____

Date:_____

Telephone Number (s):_____

St. Bonaventure University Center for Student Wellbeing

Health Care Consents Form

This form is **required** for all new students age 18 and older

Student Name:_____Student DOB:_____Student ID#:_____

Section 1: Permission to Release Medical Information to Parents/Guardians OPTIONAL but HIGHLY recommended for students over 18 yrs.

I hereby grant permission for the Center for Student Wellbeing, Health Services staff, to release medical information to the following parent(s), guardian(s), or personal representative(s). I understand that I may make exceptions to this release for certain types of information by indicating below on the "limitations" line. If I leave the line blank, I understand that there will be no exceptions for what types of medical information may be shared to the people listed below. I understand that I may make changes to this consent at any time by filling out a new consent form available through the student health portal or coming to health services and requesting a new parent information consent form.

Name of Parent/Guardian/Representative 1: _____

Relationship to Student: _____

Name of Parent/Guardian/Representative 2: _____

Relationship to Student: _____

Are there any limitations to the information which the Health Services staff may discuss with your above-listed parent(s)/guardian(s)/representative(s)?

_____

_____

_____

_____

_____

Student Signature:_____ **Date:** _____

Section 2: Permission to Release Medical Information To Emergency Responders
(REQUIRED For all students)

I hereby grant permission to the Center For Student Wellbeing, 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 or NCAA medical 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 releasing my personal information for any other purpose will require me to sign the other sections of this consent or third-party releases through the Center for Student Wellbeing.

Student Signature:_____ **Date:** _____

Section 3: **For NCAA and Club Sport Athletes Only**: Consent for communication with NCAA
OR club sports athletic staff

"I hereby give permission to the Health Services Staff to communicate by phone or other secure forms of communication with my athletic trainer and/or coach any pertinent information regarding my medical treatment that may directly affect my ability to participate in practice sessions, strength training, or games/matches/meets. Health Services will make every effort to make sure that the student is aware of all communication with the athletic trainer/coach."

I understand that MENTAL HEALTH information is NOT included in this consent, that a separate consent must be signed at time of service for mental health information to be released.

I also understand that I may ask the SBU campus doctor/medical provider to NOT share my medical information at any time.

Student Signature:_____ **Date:** _____

Indicate Sport Played: _____ Circle: NCAA CLUB