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

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

STUDENT HEALTH HISTORY FORM

Student Demographic Information				
Last Name:	First Name:		Middle Name:	
Preferred Name:	Legal Gender:	Gender Identity:	Date of Birth:	
Address:	City:		State:	Zip:
Student's Phone #:	Email:			
Emergency Contact Full Name:	Relationship:		Contact Phone:	

Preferred Pharmacy	
□ Default to closest (Walmart Pharmacy, Olean)	□ Other, pharmacy and address:

Medications (attach a separate list if needed)		□ No medications taken
Medication Name:	Dosage:	Reason for use:
(Example: Claritin)	*(10 mg daily)*	*(Seasonal Allergies)*

Allergies	□ No known drug or food allergies
Allergy:	Reaction:

Student Medical History (check box for 'yes')

□ Asthma/Lung	□ Diabetes	□ Seasonal Allergies	□ Other:
□ Cancer	□ Epilepsy/Seizures	□ Tuberculosis (TB)	
□ Cardiac/Murmurs	□ Mental Health	□ Thyroid	

Surgeries:

Family Medical History (parents, grandparents, siblings, children; check box for 'yes')

□ Blood/Bleeding Disorder	□ Respiratory Disease	□ Epilepsy/Seizures
□ Heart Disease	□ Diabetes	□ Kidney Disease
□ High Blood Pressure	□ Cancer	□ Other:

Medical Provider (Physician, Physician Assistant, Nurse Practitioner)

Name:
Address:
Phone Number:

Additional physicians/healthcare providers, such as specialists:

Name(s):

CONSENT FOR COMMUNICATION WITH PRIMARY MEDICAL PROVIDER:

"I give consent for the medical staff of St. Bonaventure Health Services to contact my primary care provider 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 at St. Bonaventure University. I understand that this consent may be revoked at any time by student's written request."

Student Signature: _____ Date:_____

If under 18 years old, parent or legal guardian signature: _____

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MANDATORY MENINGITIS NOTIFICATION AND RESPONSE FORM

This letter is 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 can cause 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 college campuses 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 years of 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, a local pharmacy, or you should consult your primary care provider.

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

******If you have received the Meningitis vaccine, this **MUST have been within the last five years (for Meningitis ACWY) or complete series (for Meningitis B) and documentation must be provided** using the guidelines outlined in the SBU Immunization Policy. ******

*Note that NYS Public Health Law 2167 requires you to complete the following section in the ***absence*** of vaccination*

☐ 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 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**

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Physical Examination Form

To be completed by your healthcare provider. Healthcare providers may submit their own physical examination form, but it must include all the following information

A **copy of your immunization records *must* be attached to this form**

Student's Full Name:				Date of Birth:
SBU Student ID #:	Date of Physical Examination:			
Allergies (include medication/food/bee sting allergies):				
Current Medications (prescription/over the counter):				
Medical History (attach a separate paper if needed):				
Ht.:	Wt.:	Temp:	B/P: /	Pulse:
Vision:	□ No Lenses	□ Lenses	R: 20/	L: 20/

Select *Normal*, *Abnormal*, or *Not Evaluated* for each row below:

PHYSICAL EXAM	Normal	Abnormal	Not Evaluated	Describe Abnormalities:
Head and Neck				
Eyes				
Ears and Hearing				
Nose and Sinuses				
Mouth and Throat				
Lymph Nodes				
Lungs and Chest				
Cardiovascular				
Abdomen (include hernia)				
Back/Spine				
Musculoskeletal				
Neurological				
Psychiatric				
If Indicated:				
Breasts				
Genitourinary				
Anus/Rectum				

Is there loss or serious impairment of any limb or organ?	□ No	□ Yes, please explain:
Is the student currently receiving treatment for any medical or emotional problem?	□ No	□ 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: _____

Date

Address/City/State/Zip: _____

Informed Consent

Welcome to Student Wellbeing – Counseling and Health Services! Please take a few moments to read the following carefully and sign below to indicate that you understand and agree. *** If you are under 18 years of age, a parent or legal guardian is required to sign this consent form.**

TREATMENT

Medical care is provided by physicians, nurse practitioners, nurses, and other assistants. Treatment may include, but is not limited to, the following: performing on-site diagnostic tests, drawing blood, routine evaluations, consultations and physical examinations, and administration of medications (if the medication is prescribed, deemed necessary or advisable by a medical provider responsible for care or treatment). Since medical care is dynamic and variable, there are no guarantees for the care and treatment of your presenting problem or a diagnostic outcome. Additionally, there are no assurances to a resolution of all symptoms.

Counseling is a process, which can take place in group or individual format. Counseling services function under a brief treatment model and counselors work collaboratively with you to both identify the presenting problems and develop a treatment plan. Counseling is provided by masters or doctoral level staff members, who are either licensed mental health counselors or social workers or pursuing a license as a mental health counselor/social worker. Counselors are ethically obligated not to work beyond their scope of practice; therefore, if your needs warrant, we will help facilitate a referral to another counselor and/or specialist within the center or in the community. The counseling process can be unpredictable and at times uncomfortable. There are no assurances to a resolution of all symptoms and at times, you may feel stuck or unsuccessful in the counseling process. If you have a trauma history, there are risks (e.g., flashbacks, dissociation, and anxiety) associated with counseling. You are encouraged to discuss these risks, as well as the benefits with your counselor.

CONFIDENTIALITY

Counseling and Medical/Health Services are integrated, in that we utilize a shared electronic health record (EHR). Please know that all records are confidential, and confidentiality will be maintained by all staff members, except under the following conditions and limitations:

1.) As needed, we seek supervision and consultation from professional colleagues within health or counseling services for integrated care and/or contracted clinical supervisors or providers (e.g., psychiatric mental health nurse practitioners) where required to aid us in our work with you. These colleagues also must treat your information as confidential, within the same legal limits.

2.) If we believe you pose an imminent danger to self or others, we must notify and collaborate with responsible individuals for your protection and/or protection of others.

3.) If we have reasonable cause to suspect child abuse or maltreatment, we are required by law to file a report with Child Protective Services. Likewise, if we have reasonable cause to suspect a vulnerable adult is being abused or maltreated, we will notify Adult Protective Services.

4.) If records are subpoenaed directly by a court, we are required by law to release records and perhaps be called to testify at those proceedings.

5.) If you are a minor (under the age of 18), we need consent for treatment from a parent or legal guardian; therefore, confidentiality cannot be guaranteed.

6.) In accordance with the NYS SAFE Act 2013 law, mental health providers are required to alert the County Director of Community Services and the NY Department of Criminal Justice Services (DCJS) if a person is likely to engage in conduct that will result in serious harm to self or others. The DCJS will then identify if that person has a gun permit and may remove firearms from their possession in order to protect the identified person or others. This law may also prevent impacted people from obtaining a gun permit for 5 years following a report to the DCJS.

7.) In accordance with the HIPAA Privacy Rule, we protect the privacy of patients' health information; however appropriate uses and disclosures of the information may be made when necessary to treat a patient, protect the nation's public health, and for other critical purposes. Protected health information may be shared with a patient's family members, relatives, friends, or other persons specifically identified by the patient for this reason. In addition, we may share information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care, of the patient's location, general condition, or death.

Informed Consent

NOTICE TO STUDENT ATHLETES: Medical information may be shared/exchanged with athletics, when necessary. Information related to counseling will be excluded, unless we receive written authorization from you to do so.

If circumstances necessitate the release of information outside of health or counseling services as outlined above, you will be notified as soon as reasonably possible. In all other situations, information may be released to appropriate individuals or agencies only upon your written request. If you have any questions regarding the above conditions, please discuss them with your provider.

FEES
All medical care and counseling visits are free to full-time enrolled students during the academic year; however, there may be a nominal fee associated with certain external services (e.g., lab tests, x-rays, and medications). These fees are charged to your insurance by the 3rd party service provider and are not associated with the university's services.

APPOINTMENT CANCELLATION / NO SHOW
Students are asked to give a minimum of 24 hours' notice in the event they need to cancel an appointment. After three cancellations or no shows, the student will be referred to an administrator (i.e., the counseling director) for a meeting.

DATA COLLECTION
Counseling and Health Services gather data for internal and external usage. We participate in regional and national associations, organizations, and projects which request aggregate data from universities and colleges for annual reports and research purposes. We only provide aggregate data, which means we contribute anonymous, numerical data provided by those who utilize our services, data is stripped of all personally identifying information. Data is utilized internally for analysis and reports as well to better understand our student needs and enhance service provisions. Since data cannot be linked to specific individuals, there are virtually no risks to contributing data.

OUTREACH
Our staff participates in a wide variety of programs and campus events. You may see us around campus in this role, and if so, please be assured that every effort will be made to protect your privacy.

EMERGENCIES
For daytime mental health crisis call the Student Wellbeing office at 716-375-2310. For after-hours mental health emergencies, contact the resident director or campus safety at 716-375-2525. For medical emergencies or after-hours medical concerns call campus safety or 911. The nearest hospital is Olean General Hospital. For mental health crisis, students can also contact the BetterMynd crisis line 24/7 while on campus at 844-287-6963 (844-BTR-MYND).

ELECTRONIC COMMUNICATION
Electronic mail (e-mail) or other electronic communication transmission is not confidential. For this reason, Counseling and Health Services discourages the sharing of compromising personal or clinical information electronically, except for secure messaging via the online Medicat patient portal. In addition, our staff may not always have immediate access to nor monitor their email communications on a daily basis; therefore, e-mail should not be used to communicate an emergency or crisis.

☐ *I have read and understand the statements above regarding informed consent and I accept these terms. I give consent for my treatment through St. Bonaventure University's Health and Counseling Services until enrollment status becomes inactive or unless otherwise revoked per student's written request. I understand that I can discuss concerns or questions with my provider at any point in the process of treatment.*

☐ *As the parent/guardian of_____, I hereby authorize St. Bonaventure University Student Wellbeing staff, to evaluate, advise, perform diagnostic procedures, 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 once my dependent reaches age 18 my consent is no longer required or otherwise revoked by written request.*

_____ _____
Print Name (Student) Date of Birth

_____ _____
Student Signature or ***Parent/Guardian Signature if under 18*** Date

_____ _____
Witness Date